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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G118		C 09/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	5051 LEE STREET NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On 7/30/2008, the State Agency (SA) received notice of Client #1's death. The facility reported that on 7/29/2008 Client #1 was transported to the emergency room via ambulance due to an irregular pulse. He was subsequently admitted to the hospital and died the following day (7/30/2008 at 1:30 pm). The actual cause of death has not been determined. It should be noted that the Client's hospital physician informed the facility that the cause of death was cardiopulmonary arrest and septic shock. Due to the nature of the incident, the state agency conducted an on-site investigation to determine the facility's compliance with the conditions of participation in Client Protections and Health Care Services. The findings of the investigation were based on interviews with the direct care staff, nursing staff, administrative staff and the review of the facility ' s medical, clinical and administrative records. On 7/31/2008, the facility's Qualified Mental Retardation Professional (QMRP) and incident Management Coordinator (IMC) were informed that the lack of appropriate and timely emergency interventions on July 6, 2008 and July 29, 2008 resulted in the neglectful oversight and management of Client #1 (deceased) care and posed an immediate risk to the remaining clients in the home. Prior to the surveyor leaving the facility, the QMRP and IMC developed new policies and trained staff on the new and existing protocols, however the facility failed to meet the participating	W 000	Received 10/8/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Linda Graham, QMRP Coordinator 10/8/08

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 000	Continued From page 1 requirements in the Conditions of Participation in Governing body, Client Protections, Facility Staffing and Health Care Services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, client and staff interviews, and record review, the governing body failed to provide general operating direction over the facility as evidenced by deficiencies cited throughout this report. The findings include: 1. The Governing Body failed to have an effective system to ensure emergency protocols were implemented. [See W127] 2. The Governing body failed to have an effective system to effectively communicate health care concerns to the Primary Care Physician. (PCP) [See W322].	W 104	W104 1. BRA has taken the follow-up steps to insure that its emergency protocols are clear and consistently implemented by staff as evidenced by the responses for W127.....10/08/08 2. BRA has taken the necessary steps to insure that the primary care physician is routinely informed about all health care concerns in a timely manner as evidenced by the responses to W322	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based staff interviews and record reviews, the facility failed to ensure the implementation of an effective system of oversight to prevent physical injury (See W127); the facility failed to ensure the	W 122		

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W 122	Continued From page 2 development and implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of a client (See W149); the facility failed to ensure the immediate reporting of an injury of unknown origin (See W153); and also failed to ensure the timely reporting of the corresponding investigation in accordance to the law (See W156). The effects of these systemic practices results in the failure of the facility to protect its clients from potential neglect, harm and to ensure their general safety and well being.	W 122	W122 BRA has taken the necessary steps to insure that appropriate client protections are in place and routinely implemented as evidenced by the responses to W127, W149, W153 and W156.....10/08/08	
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to implement an effective system of management and oversight to prevent neglect for one of five clients who resided in the facility. [Client #1 - Deceased] The findings include: 1. The facility failed to ensure that emergency protocols were implemented to prevent Client #1's neglect as evidenced below: a. At 1:30 AM on 7/6/2008 Staff #1 " noticed " that Client #1 was bleeding from his mouth. Staff #2 was called to his room to witness the client ' s condition. The decision was made to call the	W 127	W127 1a. The House Manager inappropriately addressed a medical concern communicated by staff on duty as opposed to insuring that the issue was promptly communicated to medical personnel (RN and/or primary care physician) so that they could instruct staff on appropriate follow up. This was inconsistent with BRA's emergency policy. The House Manager has been removed from the position.....10-1-08	

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W 127	Continued From page 3 House Manager (HM) to get instructions regarding the situation. In an interview with the Incident Management Coordinator (IMC) on 7/31/2008, she indicated that one of the staff persons (Staff #2) wanted to call for an ambulance to transport the client to the emergency room, while the other staff (Staff #1) insisted on calling the House Manager (HM). The staff contacted the HM via telephone and were instructed to rinse the client ' s mouth, bathe him, change the sheets and put him back to bed. The HM reportedly told the staff that the client suffered from a gum condition, (pyorrhea) and that his gums will bleed. The HM also instructed the staff to have the nurse evaluate the client when she arrived to administer the morning medications. An entry in the staffs log for 7/6/2008, at 2:30 AM (an hour after the discovery of the injuries) reflected that . . . "[Client #1] was still oozing blood from the mouth also his face was swollen especially his lip and right eye. Blood rinsed again from [Client #1 ' s] mouth." There was no indication that the physician or nursing staff had been notified of the client ' s condition at 2:30 AM. b. According to the staff log, the medication nurse entered the house at 7:40 AM. (6 hours 10 minutes after the injury was discovered). A nursing progress note, at 7:00 AM, reflected that the nurse observed Client #1 ' s " right side of face swollen; lip cheek and eye has some discoloration. . . . " Mouth currently bleeding. " . . . " Client Mouth breathing. " The nurse documented vital signs that were within normal parameters. The note indicated that the client was " sent to the emergency room for evaluation. According to the staff log, the client left the facility for the emergency room at 8:45 AM. (7 hours and 15 min after the injury was discovered.) There	W 127	1b. BRA has revised and expanded its emergency protocol to insure that the primary care physician and nursing is notified in a timely manner when there is a significant change in the medical condition of any person supported (see all the attached protocols). Staff has been trained on the new emergency protocols.....10-1-08. 1c. BRA as a practice minimizes situations where two staff members with less than 60 days experience with the company and the individuals supported, work together without a staff member that has more than nine months experience. BRA has established a new protocol that insures that at least one staff member on duty will have at least one year's experience when a fellow staff member or several have less than 60 days experience. In addition, BRA has revised its initial orientation to include emergency protocols and medical concerns. This training will be delivered by nursing and will be implemented prior to a new staff member beginning work in the home.....10-8-08 2. The medication nurse failed to inform the primary care physician and the RN about the refusals. BRA has developed a comprehensive protocol instructing nurses and staff as to how to respond when an individual refuses medications or treatments. Nurses and staff will be trained on the new protocol by.....10-8-08 It should be noted that BRA medical personal developed and implemented strategies to insure that the Cipro was taken. The medication was initially ordered in solid form. When it was refused (crushed) it was changed to liquid the next day and a strategy was developed to mix the liquid Cirpo with substances that Client #1 did like so as to successfully get it down. This strategy worked 100% of the time for one of the two medication-passing nurses but not the other. The second nurse had mixed results but as mentioned, failed to report refusals to the RN and PCP.	

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W 127	Continued From page 4 was no evidence at the time of survey to substantiate that the nurse informed the primary care physician of the client 's condition. Interview with the PCP on September 22, 2008 verified that he was not aware of the clients injury prior to him going to the ER. c. On August 1, 2008, Staff #1 and Staff #2 were interviewed. Both staff revealed they had been employed for less than 3 weeks and received minimal training on the facility incident management and/or emergency protocols. It was evident via the interviews that they were not sure how to properly handle the aforementioned emergency as it occurred. Information obtained from the interviews revealed both staff had a difference of opinion regarding who to call/contact and notify about the injury. The House Manager (HM) was notified, but no one from the medical staff or the facility ' s administrator was notified of the injury when it was discovered. The House Manager explained during her interview on August 1, 2008 that she was not provided a proper picture of the " injury " . She further indicated that she didn ' t know the injuries were as severe as they were and that she did not think much of the injury based on the information she received and due the condition of his oral health (Pyorrhea) at the time. [Also See W192] Note: Observations at the facility revealed two documents entitled BRA guide for unusual incident follow -up, posted on the facility ' s walls. It was noted that both documents indicated that . . . If the injury or illness is serious or life threatening, call 911 immediately. 2. The facility's nursing staff neglected to inform the PCP that Client #1 refused to take medication	W 127	In addition, BRA questions whether a determination of septic shock as a contributor to Client #1's death could have been determined so soon after his death (less than 24 hours). BRA knows of no cultures that were taken or any lab work that indicated infection. Client #1's WBCs were in the normal range just the day before he went to the emergency room. There were no indicators of fever and his temperature when taken was in the normal range. Client #1 was seen on by the PCP Sunday July 27th and no indication of infection was noted. During his stay in the emergency room the Providence Hospital lab tests completed on 7-29-08 demonstrated normal WBCs and normal temperatures. BRA has asked to see the Death Certificate to see what was officially indicated as the cause of death and urged a full autopsy so as to insure accurate findings.	

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W 127	Continued From page 5 as evidenced below: Client #1 was evaluated in the emergency room on 7/6/2008 for contusion to his face. He was prescribed an antibiotic at that time. The PCP recommended that the client be treated with Cipro 500 mg twice a day for 14 days. Review of the Medication Administration Record (MAR) on August 20, 2008 at 2:00 PM revealed that the client refused and/ or spit out 9 of 28 doses of medications. The record failed to reflect that the primary care physician was made aware that Client #1 had not received the Cirpo as ordered. Interview with the PCP on September 22, 2008 verified that he was not informed of the client's medication refusals. When asked what his course of action would have been had he been informed of the refusals he indicated that he would have had to explore other means of getting the medication to the client such as intravenously. It should be noted that Interview with the RN and IMC on 7/31/2008 and as documented in the facility's internal investigations revealed that the hospital physician informed them that the cause of Client #1's death was cardiopulmonary arrest and septic shock. 3. The facility failed to ensure that emergency services were contacted timely: On 7/29/2008, at approximately 5:10 PM, the facility's Registered Nurse evaluated Client #1 ' s pulse and noted that it was erratic. According to the corresponding nursing note, RN#1 called the QMRP and then called 911. The client was transported to the ER at approximately 6:30 PM (1hour and 10 minutes after having assessed Client #1 with an erratic pulse).	W 127	3, The home's new RN wrote a summary note about the erratic pulse rate and her follow up actions but the note is condensed into a single paragraph and as such lacks the detail necessary to get a true picture of exactly what occurred during her visit, particularly an accurate, full-blown chronology. In addition, the RN who visited the home and was at that point the new RN for the home was not interviewed as a part of HRA's investigation process. BRA should have insured that such an interview occurred. In addition, the RN interviewed, the long term new RN for BRA's program, did not visit the home on the day Client #1 was taken out via 911 services and had not spoken to the new RN about the events of that particular evening. Both the BRA internal investigation and statements and the IMEU investigation and interview statements give a clearer picture about the events.....08/13/08. The new RN is new to BRA and the people it supports but not to the ICF service industry. She has many years experience. The new RN did not call the QMRP to inquire as to what she should do. She did not call the QMRP. A staff member called the QMRP to inform her of the situation. In the process, the new RN and QMRP spoke. The new RN had already determined that Client #1 needed to go to emergency and 911 was called by staff. The RN asked the QMRP if BRA would transport Client #1 via its own vehicles in the event that the EMTs determined that he did not need to go to ER through their service. The question was asked because other than his erratic pulse and the low tone moaning he was exhibiting, Client #1 was exhibiting no other signs of distress. His breathing was normal; he did not appear to be in pain. He was calmly sitting on the couch at that point.	

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W 127	Continued From page 6 Interview with the QMRP on 7/31/2008 revealed that the RN contacted her to get instruction on " what to do " regarding the client. The QMRP instructed the RN to send the client to the hospital via ambulance. There was no evidence that the client's PCP was informed of the client's condition prior to him being transported to the ER. Interview with the consultant RN acknowledged that the nurse should have used her nursing judgment and called 911 and the PCP instead of a non-medical employee (QMRP).	W 127	Because of the condensed nature of the nursing note mentioned and the lack of an interview of the RN, the chronology outlined in the deficiency document is incorrect. The new RN arrived at the home at approximately 5pm. She immediately began to perform other duties involving the medication cabinet and record. At approximately 5:25pm she was called by a staff member and asked to support her efforts to manage Client #1 during a toileting interval. He was resisting her efforts to support him at the time. The new RN did assist and subsequent to helping him the new RN sat with him on the couch. It was at that point, approximately 5:45pm that the new RN became aware of the erratic pulse and a low moaning sound client #1 was making. She assessed him and determined he needed to go to emergency. 911 was called at approximately 5:55pm. The new RN spoke to the EMTs while they were in route and informed them of Client #1's symptoms and condition. The EMTs arrived in 15 to 20 minutes but did not leave immediately. Work was done with Client #1 in the home to stabilize him and prepare him to go out. That took 20-30 minutes. The departure time of 6:40pm is accurate. BRA acknowledges that all of this should have been documented more fully and accurately in the records on the day of the event. Incident report development will be retrained by...10/08/08. The new RN will be supplied with BRA's guide for nursing notes...10/08/08. As indicated earlier, the RN interviewed was not in the home during the event, had not spoken to the new RN about the event and her follow up steps and therefore was not in a position to accurately respond to the questions asked her about it.....10/08/08.	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to effectively implement emergency protocols to prevent client neglect and to ensure clients' safety. The finding includes: Review of the facility's emergency protocol revealed " If the injury or illness is serious or life threatening, call 911 immediately. " Interviews with the Consultant Registered Nurse and the Incident Management Coordinator (IMC) revealed that the facility failed to ensure that direct care staff implemented emergency protocols when there was a medical emergency on 7/6/2008 and 7/29/2008. The failures resulted in the medical neglect of Client #1 (deceased) [Cross Reference W127]	W 149	W149 BRA as a practice minimizes situations where two staff members with less than 60 days experience with the company and the individuals supported, work together without a staff member that has more than nine months experience. BRA has established a new protocol that insures that at least one staff member on duty will have at least one year's experience when a fellow staff member or several have less than 60 days experience. In addition, BRA has revised its initial orientation to include emergency protocols and medical concerns. This training will be delivered by nursing and will be implemented prior to a new staff member beginning work in the home.....10/08/08	

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W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the timely notification of an injury of unknown origin in accordance with District policies. The finding includes: Review of the facility's incident reports revealed Client #1 was discovered with an injury of unknown origin on 7/6/2008 at approximately 1:30 AM. There was no evidence that the facility's administrator was notified immediately of the incident. [Cross Reference W127]	W 153	W153 All staff will be retrained on the notification change for serious reportable incidents by.....10/08/08	
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 staff interview and record review, the facility ' s Qualified Mental Retardation Professional (QMRP) failed to ensure effective oversight over the facility as presented below: The findings include:	W 159		

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W 159	Continued From page 8	W 159		
	1. The facility ' s Qualified Mental Retardation Professional (QMRP) failed to ensure that the overnight staff had been effectively trained to ensure client safety. [See W127 and W183] 2. The facility ' s Qualified Mental Retardation Professional (QMRP) failed to ensure that the direct care staff and House Manager (HM) were competent in the care and treatment of clients during emergent situations. [See W192]		W159 1. All staff will be retrained on the revised emergency protocol and on health concerns by.....10/08/08 2. See responses for tag W192.....10/08/08	
W 183	483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure competently trained staff during the overnight shift to manage and provide care for clients during an emergent situation. The findings include: The facility's staff failed to follow the facility's protocol in a competent manner as evidenced by the following:	W 183		

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W 183	Continued From page 9 Client #1 was discovered with a severe mouth injury during the early morning hours on 7/6/2008. On 8/1/2008, both of the staff who worked the morning shift on 7/6/2008 was interviewed. Both staff revealed they where only employed a few weeks/less than a month, had received minimal training prior to starting their tour of duty and it was evident via the interview that they were not sure how to properly handle the situation. As gathered from the interviews, both staff had a difference of opinion regarding who to call and notify about the injury and neither staff contacted 911 or any medical personnel. [Cross Reference W127]	W 183	W183 BRA will insure that staff with less than 60 days experience work with at least one staff member with more than nine months experience.....10/01/08 In addition, the staff orientation has been revised to include emergency protocols and medical procedures as delivered by nursing personnel.....10/08/08	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure effective training to the staff regarding securing health care services for Client #1. The finding includes: 1. The facility ' s nursing staff failed to show evidence of effective training on securing emergency services for clients who have changes in their health status. [See W331] 2. The incident report received at the State Agency on reflected that on July 7, 2008 at 1:30 AM, Client #1 was found in his bed bleeding from his mouth and his face was swollen. There was two staff on duty at the time. According to	W 192	W192 1. See responses for W331 2. Emergency procedures have been revised and staff has been retrained to insure that all staff understand the mandate to call nursing and as instructed the PCP.....10/08/08	

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W 192	Continued From page 10 interview with the facility ' s incident management coordinator (IMC) on 7/31/2008 at approximately 2:30 PM, one of the staff (Staff #2) wanted to send the client to the hospital 911, and the other staff (Staff #1) wanted to call the house manager. The house manager was called and informed of the client ' s condition. The House manager instructed the staff to have the nurse evaluate the client because the client had a history of Pyorrhea and had experienced bleeding gums in the past. At approximately 7:30 AM, (six hours later) the nurse assessed the client and instructed the staff to get the client to the Emergency Room. Although the corresponding incident report indicated that the client was transported to the hospital 911, the IMC indicated that the client was transported via facility van. The Client was treated in the emergency room and released back to the facility with a diagnosis of contusion to the face. Interview with the Consultant Registered Nurse (C-RN) and the IMC verified that the staff should have called an ambulance to have Client #1 transported to the ER when his injury was discovered at 1:30 AM. It should be noted that there was no evidence that a health care professional i.e. a nurse or the PCP was made aware of the client ' s condition when it was discovered. [Cross Reference W127] 3. On 8/1/2008, the House Manager was interviewed and she explained that she was not provided a proper picture of the " injury " and as such advised the staff to " wash him up and put him back to bed " due to his history of bleeding gums and Pyorrhea. She further indicated that she didn ' t know the injuries were as severe as	W 192	3. The House Manager did not take the additional steps necessary to inform the proper medical personnel and has been removed from the position.....10-8-08	

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W 192	Continued From page 11 they were and that she did not think much of the injury based off to the information she received and due the condition of his oral health at the time. There was no evidence on file or presented during the investigation to substantiate that the House Manager (HM) took any additional steps to ascertain the nature and severity of Client #1 ' s injuries. 4. There was noe evidence that , Staff #1, Staff #2, and the house manager had been affectively trained on the emergency protocols of the facility as evidenced by the following: At 1:30 AM on 7/6/2008 Staff #1 " noticed " that Client #1 was bleeding from his mouth. Staff #2 was called to his room to witness the client ' s condition. The decision was made to call the House Manager (HM) to get instructions regarding the situation. In an interview with the Incident Management Coordinator (IMC) on 7/31/2008, she indicated that one of the staff persons (Staff #2) wanted to call for an ambulance to transport the client to the emergency room, while the other staff (Staff #1) insisted on calling the House Manager (HM). Interview with the IMC and QMRP on July 30, 2008 at 3:00pm revealed that the staff should have called 911 to secure emergency services for the client. The staff contacted the HM via telephone and were instructed to rinse the client ' s mouth, bathe him, change the sheets and put him back to bed. The HM reportedly told the staff that the client suffered from a gum condition, (pyorrhea) and that his gums will bleed. The HM also instructed the staff to have the nurse evaluate the client when she arrived to administer the morning	W 192	4. Staff retrained on emergency response.....10/08/08	

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W 192	Continued From page 12 medications. An entry in the staffs log for 7/6/2008, at 2:30 AM (an hour after the discovery of the injuries) reflected that . . . "[Client #1] was still oozing blood from the mouth also his face was swollen especially his lip and right eye. Blood rinsed again from [Client #1 ' s] mouth." There was no indication that the physician or nursing staff had been notified of the client ' s condition at 2:30 AM. There was no evidence that the HM called the nurse to inform him/her of the client's condition once she was notified. Interview with the IMC and the QMRP on July 30, 2008 at 3:00pm revealed that the HM should have instructed the staff to call 911 and that the nurse should have been notified. It should be noted that according to the staff log, the medication nurse entered the house at 7:40 AM. (6 hours 10 minutes after the injury was discovered). A nursing progress note, at 7:00 AM, reflected that the nurse observed Client #1 ' s " right side of face swollen; lip cheek and eye has some discoloration. . . . " Mouth currently bleeding. " . . . " Client Mouth breathing. " The nurse documented vital signs that were within normal parameters. The note indicated that the client was " sent to the emergency room for evaluation. According to the staff log, the client left the facility for the emergency room at 8:45 AM. (7 hours and 15 min after the injury was discovered).	W 192		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by:	W 318		

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NAME OF PROVIDER OR SUPPLIER: BRA

STREET ADDRESS, CITY, STATE, ZIP CODE: 5051 LEE STREET NE, WASHINGTON, DC 20019

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W 318	Continued From page 13 Based on observation, interviews, and record review, the facility failed to ensure that staff in the home and the nursing staff demonstrated competency in implementing Emergency procedures [Cross-refer to W127 and W192]; failed to provide preventive and general health care services to meet the needs of the clients [Cross-refer to W322]; and failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross-refer to W331]; The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	W318 BRA has insured the system corrections have been put in place to insure that health care services are consistently provided as evidenced by the responses to W127, W192, W322 and W331.....10/08/08	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to provide timely medical care services for Client #1(deceased). The findings include: The facility failed to ensure timely health care as evidenced below: 1. At 1:30 AM on 7/6/2008 staff #1 " noticed " that Client #1 was bleeding from his mouth. Staff #2 was called to his room to witness the client ' s condition. The decision was made to call the House Manager (HM) to get instructions regarding the situation. In an interview with the incident management coordinator (IMC) on	W 322	W322 1. Staff has been retrained to insure that appropriate notifications to all parties necessary occur under such circumstances.....10/08/08	

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W 322	Continued From page 14 7/31/2008 she indicated that one of the staff persons wanted to call for an ambulance to transport the client to the emergency room, while the other staff insisted on calling the HM. The HM instructed the staff via telephone to rinse the client ' s mouth, bathe him, change the sheets and put him back to bed. The HM reportedly told the staff that the client suffered from a gum condition, (pyorrhea) and that his gums will bleed. The HM told the staff to have the nurse evaluate the client when she arrived to administer morning medications. An entry in the staffs log for 7/6/2008, at 2:30 AM reflected that . . . "[Client #1] was still oozing blood from the mouth also his face was swollen especially his lip and right eye. Blood rinsed again from [Client #1 ' s] mouth." There was no indication that the physician or nursing staff had been notified of the client ' s condition at 2:30 AM. Observations at the facility revealed two documents entitled BRA guide for unusual incident follow -up, posted on the facility ' s walls. It was noted that both documents indicated that . . . If the injury or illness is serious or life threatening, call 911 immediately. 2. On 7/29/2008, at approximately 5:10 PM, the facility's Registered Nurse (RN#1) evaluated Client #1 ' s pulse and noted that it was erratic. According to the corresponding nursing note, RN#1 called the QMRP and 911. The client was transported to the ER at approximately 6:30 PM. (1hour and 10 minutes later). Interview with the QMRP on 7/31/2008 revealed that the RN contacted her to get instruction on "what to do" regarding the client. The QMRP told RN#1 to send the client to the hospital via ambulance. It should be noted that a non medical person (the	W 322	2. The new emergency protocol clearly instructs all to make immediate 911 calls under such circumstances. Staff has been trained and the new RNs helped develop the revised policy for the company 10/08/08	

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W 322	Continued From page 15 QMRP) was informed of the client ' s condition and there was no evidence that the Primary Care Physician was notified of the client ' s condition prior to him being transported to the ER. Interview with the consultant RN acknowledged that 911 and the PCP instead of the QMRP should have been notified of the client ' s condition. It should be noted he was admitted to the hospital and died the next day (7/30/2008). 3. The facility failed to ensure its nurses reported client's refusal of medications. [See W331.3] 4. The facility failed to ensure its nurses transcribed onto the MAR and initiated prescribed medication. [See W331.4 a & b] 5. The facility failed to ensure its nurses recorded the effects of medications prescribed for coughing. [See W331.7]	W 322	3. A new protocol has been developed and nurses have been trained on it addressing follow up in the event a person refuses medications, eating or treatments.....10/08/08 4. A new protocol has been developed and nurses have been trained by RN Coordinator on it to insure that new medications ordered and approved by the PCP are transcribed onto the MARs within 24 hours.....10/08/08 5. The RN Coordinator retrained the medication nurses along with the new RNs on insuring they document the effects of medications, particularly new or PRN medications.....10/08/08 The new RNs will monitor routine compliance via at minimum weekly reviews of the Medication Administration Records.....10/08/08	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide nursing care in accordance with client needs. The findings include: 1. The facility' nursing staff failed to secure timely emergency care for Client #1 as evidenced below:	W 331	W331 1. See responses for W127	

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W 331	Continued From page 16 At 1:30 AM on 7/6/2008 staff #1 " noticed " that Client #1 was bleeding from his mouth. A decision was made to report the incident to the house manager (HM). The house manager instructed the staff told the staff to have the nurse evaluate the client when she arrived to administer morning medications. An entry in the staffs log for 7/6/2008, timed 2:30 AM reflected that . . . "[Client #1] was still oozing blood from the mouth also his face was swollen especially his lip and right eye. Blood rinsed again from [Client #1's] mouth " According to the staff log, the nurse entered the house at 7:40 AM. (6 hours 10 minutes after the injury was discovered). A nursing progress note, however, indicated that the nurse assessed Client #1 at 7:00 AM. The nurse ' s assessment revealed the client ' s " right side of face swollen; lip cheek and eye has some discoloration. . . . Mouth currently bleeding . . . Client Mouth breathing. " The nurse documented vital signs that were within normal parameters. The note indicated that the client was " sent to the emergency room for further evaluation. According to the staff log, the client left the facility for the emergency room at 8:45 AM. (7 hours and 15 min after the injury was discovered.) There was no evidence that the nurse informed the physician of the client ' s condition. [Cross Reference to W127] 2. An interview with the facility ' s RN Consultant on 7/31/2008 at approximately 2:40 PM revealed that the facility's Registered Nurse assessed Client #1 on 7/29/2008 and found the client ' s pulse to be erratic. The nurse reportedly called the QMRP to seek advice on what actions to take. The QMRP was interviewed on 7/31/2008 at appropriately 2:40 PM and acknowledged that she instructed the nurse to call 911. Both the RN	W 331	2. The true chronology of events is outlined in the responses for W127. Emergency 911 calls are mandated in such situations under the new protocol.....10-8-08	

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W 331	Continued From page 17 Consultant and the QMRP indicated that the new nurse did not take immediate action to secure timely health care services for Client #1. [Cross Reference to W127]	W 331		
	3. The facility's nursing staff failed to have evidence that the Primary Care Physician (PCP) was made aware of Client #1's refusal to take medication. a. Client #1 was evaluated in the emergency room on 7/6/2008 for contusion to his face. He was prescribed an antibiotic at that time. The PCP recommended that the client be treated with Cipro 500 mg twice a day for 14 days. Review of the medication administration record (MAR) on August 20, 2008 at 2:00 PM revealed that 9 of 28 doses of medication was either refused by the client or the client spit out the medication. The record failed to reflect that the primary care physician was made aware that the client had not received the medication as ordered. b. Review of the MAR's on September 9, 2008 revealed Client #1 refused all or some of his routine medications in the months of 4/08, 1/08, 2/08, 5/08, and 7/08. The nurse noted on the MAR "not given, poured out, or discarded" There was no corresponding PCP note or order to acknowledge that he was notified of the clients refusal to take medications.		3. The new protocol for refusal of medication or treatments outlines appropriate responses for such situations. Staff and nurses have been trained on the mandates.....10-8-08 4. The Levaquin 500mg was ordered as indicated on 7-27-08 and was not transcribed onto the MARs by 7-29-08, the day he went to emergency. Orders will be transcribed within 24 hours henceforth as per the new protocol.....10-8-08	
	4. The facility's nursing staff failed to appropriately transcribe and initiate medication orders as written by the Primary Care Physician (PCP): a. The nursing note, dated 7/27/2008 reflected			

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W 331	Continued From page 18 that Client #1 had a continuous cough and had been refusing all solid food. On 7/27/2008, the client's PCP evaluated the client and noted that the client had a decreased appetite, a clear chest, but and that his pulse rate and rhythm was irregular. The PCP's note further indicated that his assessment was "bronchitis/pneumonia". The record revealed a physician's order (PO's) dated 7/27/2008 (documented on the 5/ 2008 physician's order sheet) for Levaquin 500 mg (1 tablet every day for 14 days). The order was countersigned by the LPN (not dated). The July 2008 MAR, however failed to show evidence that the order was transcribed on the MAR and that the medication was initiated, however, the PO ' s for 8/ 2008 reflected the transcription of the order. It should be noted that Interview with the RN and IMC on 7/31/2008 and as documented in the facility's internal investigations revealed that the hospital physician told them that the cause of Client #1's death was cardiopulmonary arrest and septic shock. b. Review of the physician's orders on September 9, 2008 revealed that the PCP ordered Actifed on 4/7/08 for congestion. The MAR's for 4/08 failed to show evidence that the medication was transcribed on the MAR by the nurses. 5. The facility's nursing staff failed to have evidence of notifying the PCP of the clients decreased appetite: Review of Client #1's medical record on 7/31/2008 revealed the following notations regarding the eating habits of this client from 7/7/2008 through 7/27/2008:	W 331	It should be noted that Client #1 had a chest x-ray done on 7-28-08 that showed no signs of infection to the lungs. 5. In the future, when an individual supported is tracked for food consumption and appetite, a person-specific protocol will be developed that	

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W 331	Continued From page 19 7/7 - Poor appetite 7/8 - Appetite increased from 7/7 7/9 - Ate very little 7/10 - (no notations) 7/11 - Decreased appetite 7/12 - 7/16 - (no notations) 7/17 - 7/22 - (no notations) 7/23 - (no notations) 7/24 - 7/26 - (no notations) 7/27 - Not eating solid food but drinking soda ensure and juice. He was evaluated by the PCP on this date. There was no evidence that the clients decreased food intake was consistently documented and reported to the primary care physician prior to 7/27/08. 6. The facility's nursing staff failed to have evidence that the PCP was made aware of client #1's cough: At 1:30 AM on 7/6/2008 staff #1 " noticed " that Client #1 was bleeding from his mouth. According to the staff interviews, when they sat the client up from a lying position he started to cough. The PCP evaluated by the the client on July 7, 2008. The PCP ordered x-rays and antibiotics (Cipro). It was noted in the record that from July 8, 2008 through 7/27/2008 the nursing staff documented the client coughing. Although the client was prescribed antibiotics on July 7, 2008, the record reflected that on 9 of 28 administrations, the client refused the antibiotic. There was no evidence that the PCP was made aware that the client continued to cough from July 7, 2008 through 7/27/2008. It should be noted that the record reflected that as far back as March 2008, the client had a	W 331	outlines when the PCP, nutritionist and RN should be notified (for example if at least one meal is not consumed for 3 consecutive days or no meals are consumed for 2 consecutive days). A protocol will be put in place and the Health Management Care Plan will be modified to reflect the mandates. Staff will be trained on reporting parameters and observing, describing and proper data collection.....10/08/08 In addition, the protocol and HMCP will outline the parameters of weight checks and when they should be done (daily, weekly, monthly).....10/08/08 6. Cipro 500mg was ordered subsequent to a dental appointment to extract teeth that had been damaged when Client #1 hit his mouth during the night. Levaquin was ordered on 7-27-08 in response to the PCP's assessment of "bronchitis/pneumonia" along with a chest x-ray. The chest x-ray was done on 7-28-08 and showed no signs of infection to the lungs. The lungs were clear. (See: attached copy)...10-1-08. The RNs meet with the PCP monthly to discuss each person supported and review the status of all medical concerns. BRA's new protocol mandates same day communication with the PCP for any significant change in medical condition or to communicate any outstanding concern (like an illness persisting despite treatment).....10/08/08	

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

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W 331	Continued From page 20 non-productive to productive cough for which he was medicated with Robitussin. 3/25 - Non productive cough 3/26 - Non productive cough 3/28 - Non productive cough 4/1- 4/3 - Non productive cough [was seen in PCP's office for bilateral peripheral insufficiency].There was no mention that the PCP was notified of the coughing. The PCP in his 4 /1/08 note that the client ' s chest was clear on assessment. 4/4 - The nurse documented, ". . . with now productive cough, Robitussin 5 cc PO (by mouth) administered. Temp. 100.0 via temporal scanner. Staff reported excessive sweating and chills during early evening. Consumer will remain home today." There was no corresponding physician note to evidence that he was made aware of the client's condition. It should be noted that a nursing note on the same day reflected that the client's cough was non-productive 4/5-4/9 - The client continued to have coughing treated with Robitussin. The PCP ordered Actifed on 4/7/08 for congestion. 7. The facility's nurses failed to document the effectiveness of Robitussin. Review of the MAR's for the months of 7/08, 4/08, and 3/08 reflected that the client received Robitussin for coughing, however the nurses indicated on the MAR "pending". 8. The facility failed to have evidence that Client #1's Health Risk Management Care Plan (HRMCP) was updated to reflect current actual	W 331	7. Nurses retrained on documenting the effectiveness of medication.....10/08/08 In addition the RNs will review the MARs to insure routine compliance (at minimum weekly).....10/08/08 8. BRA has communicated formally with both RNs to insure that Health Management Care Plans are updated routinely to reflect changes in specific health concerns, acute concerns or new, chronic concerns. Plans will be audited by the QA Consultant, QMRPs and BRA administrators on a periodic basis to insure follow up.....10/08/08	

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W 331	Continued From page 21 and or potential problems as evidenced below: a. Review of the HRMCP evaluated by the RN Consultant on July 7, 2008 failed to reflect that due to the nature of the clients injuries sustained on 7/6/2008 he was at risk for infection and was being treated with antibiotics. b. Review of the HRMCP evaluated by the RN Consultant on July 7, 2008 failed to reflect that due to the nature of the clients injuries sustained on 7/6/2008 he was at risk for pain.	W 331	8. BRA has communicated formally with both RNs to insure that Health Management Care Plans are updated routinely to reflect changes in specific health concerns, acute concerns or new, chronic concerns. Plans will be audited by the QA Consultant, QMRPs and BRA administrators on a periodic basis to insure follow up.....10/08/08	

Health Regulation Administration

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I 000	INITIAL COMMENTS On 7/30/2008, the State Agency (SA) received notice of Client #1's death. The facility reported that on 7/29/2008 Client #1 was transported to the emergency room via ambulance due to an irregular pulse. He was subsequently admitted to the hospital and died the following day (7/30/2008 at 1:30 pm). The actual cause of death has not been determined. It should be noted that the Client's hospital physician informed the facility that the cause of death was cardiopulmonary arrest and septic shock. Due to the nature of the incident, the state agency conducted an on-site investigation to determine the facility's compliance with the conditions of participation in Client Protections and Health Care Services. The findings of the investigation were based on interviews with the direct care staff, nursing staff, administrative staff and the review of the facility ' s medical, clinical and administrative records.	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 observations, client and staff interviews, and record review, the governing body failed to provide general operating direction over the facility as evidenced by deficiencies cited throughout this report. The findings include:	I 180		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Graham, QMRP Coordinator TITLE 10/8/08 (X6) DATE

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	HFD03-0079		09/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 180	Continued From page 1	I 180		
	1. The Governing Body failed to have an effective system to ensure emergency protocols were implemented. [See Federal Deficiency Citation W127]		3508.1 1. Please refer to federal deficiency W127.....10/08/08	
	2. The Governing body failed to have an effective system to effectively communicate health care concerns to the Primary Care Physician. (PCP) [See Federal Deficiency Report Citation W322].		2. Please refer to federal deficiency W127.....10/08/08	
I 227	3510.5(d) STAFF TRAINING	I 227		
	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 staff interview and record review, the GHMRP failed to ensure competently trained staff during the overnight shift to manage and provide care for residents during an emergent situation.			
	The findings include:			
	The GHMRP ' s staff failed to follow the GHMRP ' s protocol in a competent manner as evidenced by the following:		3510.5 Please refer to federal deficiency W127.....10/08/08	
	Resident #1 was discovered with a severe mouth injury during the early morning hours on 7/6/2008. On 8/1/2008, both of the staff who worked the morning shift on 7/6/2008 were interviewed. Both staff revealed they were only employed a few			

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I 227	Continued From page 2 weeks (less than a month) and received minimal training prior to starting their tour of duty. It was also evident from the interview that they were not sure how to properly handle emergency situations. [Cross Reference Federal Deficiency Report Citation W127]	I 227		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter. Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt and adequate medical attention, as evidenced below: The findings include: 1. The facility failed to ensure that emergency protocols were implemented to prevent Resident #1's neglect as evidenced below: a. At 1:30 AM on 7/6/2008 staff #1 " noticed " that Resident #1 was bleeding from his mouth. Staff #2 was called to his room to witness the resident ' s condition. The decision was made to call the House Manager (HM) to get instructions	I 500	3523.1 Please refer to federal deficiency W127, W192, W322 and W331 .....10/08/08	

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I 500	Continued From page 3 regarding the situation. In an interview with the incident management coordinator (IMC) on 7/31/2008 she indicated that one of the staff persons wanted to call for an ambulance to transport the resident to the emergency room, while the other staff insisted on calling the HM. The facility ' s HM was contacted via telephone and she instructed the staff to rinse the resident ' s mouth, bathe him, change the sheets and put him back to bed. The HM reportedly told the staff that the resident suffered from a gum condition, (pyorrhea) and that his gums will bleed. The HM also instructed the staff to have the nurse evaluate the resident when she arrived to administer the morning medications. An entry in the staffs log for 7/6/2008, at 2:30 AM (an hour after the discovery of the injuries) reflected that . . . "[Resident #1] was still oozing blood from the mouth also his face was swollen especially his lip and right eye. Blood rinsed again from [Resident #1 ' s] mouth." There was no indication that the physician or nursing staff had been notified of the resident ' s condition at 2:30 AM. b. According to the staff log, the nurse entered the house at 7:40 AM. (6 hours 10 minutes after the injury was discovered). A nursing progress note, at 7:00 AM, reflected that the nurse observed Resident #1 ' s " right side of face swollen; lip cheek and eye has some discoloration. . . . " Mouth currently bleeding. " . . . " Resident Mouth breathing. " The nurse documented vital signs that were within normal parameters. The note indicated that the resident was " sent to the emergency room for evaluation. According to the staff log, the resident left the facility for the emergency room at 8:45 AM. (7 hours and 15 min after the injury was discovered.) There was no evidence at the time of survey to substantiate that the nurse informed	I 500		

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I 500	Continued From page 4 the primary care physician of the resident 's condition. c. On August 1, 2008, Staff #1 and Staff #2 were interviewed. Both staff revealed they had been employed for less than 3 weeks and received minimal training on the facility incident management and/or emergency protocols. It was evident via the interviews that they were not sure how to properly handle the aforementioned emergency as it occurred. Information obtained from the interviews revealed both staff had a difference of opinion regarding who to call/contact and notify about the injury. The House Manager (HM) was notified, but no one from the medical staff or the facility ' s administrator was notified of the injury when it was discovered. The House Manager explained during her interview on August 1, 2008 that she was not provided a proper picture of the " injury " . She further indicated that she didn ' t know the injuries were as severe as they were and that she did not think much of the injury based off to the information she received and due the condition of his oral health (Pyorrhea) at the time. [Also See W192] Note: Observations at the facility revealed two documents entitled BRA guide for unusual incident follow -up, posted on the facility ' s walls. It was noted that both documents indicated that . . . If the injury or illness is serious or life threatening, call 911 immediately. 2. The facility's nursing staff neglected to inform the PCP that Resident #1 refused to take medication as evidenced below: Resident #1 was evaluated in the emergency room on 7/6/2008 for contusion to his face. He was prescribed an antibiotic at that time. The	I 500		

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I 500	Continued From page 5 PCP recommended that the resident be treated with Cipro 500 mg twice a day for 14 days. Review of the medication administration record (MAR) on August 20, 2008 at 2:00 PM revealed that the resident refused and or spit out 9 of 28 doses of medication. The record failed to reflect that the primary care physician was made aware that Resident #1 had not received the Cirpo as ordered. It should be noted that Interview with the RN and IMC on 7/31/2008 and as documented in the facility's internal investigations revealed that the hospital physician informed them that the cause of Resident #1's death was cardiopulmonary arrest and septic shock. 3. The facility failed to ensure that emergency services were contacted timely: On 7/29/2008, at approximately 5:10 PM, the facility's Registered Nurse evaluated Resident #1 ' s pulse and noted that it was erratic. According to the corresponding nursing note, RN#1 called the QMRP and then called 911. The resident was transported to the ER at approximately 6:30 PM (1hour and 10 minutes later after having assessed Resident #1 with an erratic pulse). Interview with the QMRP on 7/31/2008 revealed that the RN contacted her to get instruction on " what to do " regarding the resident. The QMRP instructed the RN to send the resident to the hospital via ambulance. There was no evidence that the resident's PCP was informed of the resident ' s condition and there was no evidence that the Primary Care Physician was notified of the resident ' s condition prior to him being transported to the ER. Interview with the consultant RN acknowledged that the nurse should have used her nursing	I 500		

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I 500	Continued From page 6 judgment and called 911 and the PCP instead of a non-medical employee (QMRP). [Cross Refernce Federal Deficiency Report W127, W322 and W331]	I 500		