

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted on September 21, 2010, through September 23, 2010. The survey was initiated utilizing the fundamental process; however, due to concerns in the area of incident reporting, the process was extended to review the facility's level of compliance in the Conditions of Participation (CoP) for Client Protections and Health Care Services.

A random sample of three clients was selected from a population of six females with various levels of mental retardation and disabilities.

The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records, including incident/investigation reports.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
11-24-10

W 111 483.410(c)(1) CLIENT RECORDS

W 111 W111

10/23/10

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure treatment records were accurately maintained for two of six clients residing in the facility. (Clients #3 and #5)

The findings include:

1. The facility failed to ensure each client's medication administration record (MAR) was accurately maintained, as evidenced below:

ILS Program Director provided training with the LPN Coordinator and LPNs responsible for passing medications on the Medication Administration Policy and Procedures, including documentation and maintaining medical records on 10/21/10. RN Supervisor will continue to provide quarterly medical record audits to prevent any further deficiency in this area.

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

TITLE

(X6) DATE

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 111 Continued From page 1

W 111

a. Observation of the medication administration on September 21, 2010, at 8:46 a.m., revealed Client #3 received Klonopin 2 mg, Therobec Plus, Seroquel 300 mg, Cogentin 2 mg, Topamax 100 mg, Depakote DR 500 mg, Calcium 600/D400 and artificial tear drops. Review of the MAR on September 21, 2010 at 9:35 a.m., revealed that the client was to receive Bactrim DC, however, the client did not receive the Bactrim.

Review of Client #3's physician orders (POS) dated September 2010, after the medication administration, revealed an order for Bactrim DC, one tablet, twice a day for 10 days, for cellulitis of right deltoid. Further review of the MAR indicated that the client began receiving the medication on the morning of September 1, 2010 through September 21, 2010 (totaling 21 doses). Interview with the medication nurse indicated that the documentation was an oversight.

b. Reconciliation of Client #5's medication with the POS and MARs on September 21, 2010, at 9:30 a.m., revealed that Fluticasone 50 mcg nasal spray, one to two sprays, twice a day was prescribed for one week. Further review of the MARs revealed the medication had been signed off as given on September 21, 2010, however, was not administered. Continued review of the MARs also revealed that the nasal spray began on September 9, 2010, (in the morning) and ended on September 21, 2010.

c. Observation during the medication administration on September 21, 2010, at 8:20 a.m., revealed Client #5 punching Triam/HCTZ 37.5 mg tablet from a bubble package, with assistance from the medication nurse.

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W 111	Continued From page 2 Reconciliation of Client #5's medication observation with the POS and MARs on September 21, 2010, at 9:30 a.m., revealed that Trint/HCTZ 37.5 mg tablet was prescribed on September 1, 2010. According to the September 2010 MARs, the Trint/HCTZ 37.5 mg tablet was not signed by the medication nurse for the entire month of September 2010. Interview with the medication nurse indicated that it was an oversight. She further indicated that all medications administered should be signed by the licensed personnel who administers them.	W 111		
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 interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the three clients included in the sample. (Clients #1 and #3) The findings include: 1. Observations during the medication administration, on September 21, 2010, at 8:52 a.m., revealed that Client #1 received Fluvoxamine 50 mg (Luvox). Interview with the	W 124	W124 Due to ILS difficulty in getting client #3 family/guardian to cooperate with maintaining compliance with policies and procedures, documentation was submitted to the District Court for client #3 to have a court appointed guardian. ILS is currently awaiting court response. Due to ILS difficulty getting client #1 family/guardian to cooperate with maintaining compliance with policies and procedures, a case conference was initiated to discuss the need for client #1 to have a court appointed guardian, however according to the DDS Service Coordinator, client #1 does not qualify for a court-appointed guardian since she has available family involvement.	10/23/10

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<p>W 124 Continued From page 3</p> <p>Licensed Practical Nurse (LPN) after the medication administration indicated that the client received the medication for her maladaptive behaviors.</p> <p>Review of the client's current physician orders (POs) dated September 2010, on September 21, 2010, at approximately 3:35 p.m., confirmed the aforementioned medication. Further review of the POs revealed an initial order date of February 6, 2010 for the Luvox 50 mg.</p> <p>Review of Client #1's Psychological Assessment dated June 13, 2010, on September 22, 2010, at approximately 11:01 a.m., revealed that the client was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the medications.</p> <p>The facility failed to provide evidence that the potential risks involved in using this medication, or her right to refuse treatment had been explained to the client and/or her family member until after the medication was prescribed then administered.</p> <p>2. The facility failed to provide evidence that informed consent was obtained from Client #3's family member for psychotropic medications as evidenced below:</p> <p>Observations during the medication administration, on September 21, 2010, at 8:46 a.m., revealed that Client #3 received Klonopin 2 mg, Seroquel 300 mg, Cogentin 2 mg, and Depakote DR 500 mg. Interview with the</p>	<p>W 124 For all individuals, a signed consent will be obtained for all prescribed psychotropic medications. Program Director provided training with the QMRP, House Manager, and LPN Coordinator on 10/18/10 on ILS Policy and Procedures for obtaining consent for the use of psychotropic medications. Risks and benefits of each medication and the right to refuse treatment will be discussed with the individual and their legal guardian. ILS will obtain consent following medication changes made by the prescribing psychiatrist or at least annually during the scheduled ISP to ensure consents are maintained in the future.</p>	<p>10/23/10</p>
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W 124 Continued From page 4

Licensed Practical Nurse (LPN) after the medication administration indicated that the client received the aforementioned medication for anxiety and maladaptive behaviors.

Review of the client's current physician orders dated September 2010, on September 21, 2010, at approximately 10:50 a.m., confirmed the aforementioned medications. In addition, the client was ordered Haloperidol injection, 50 mg every seven days for combative aggressive behavior.

Review of Client #3's Psychological Assessment dated July 24, 2009, on September 21, 2010, at approximately 3:00 p.m., revealed that the client was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the medications.

The facility failed to provide evidence that the potential risks involved in using this medication, or her right to refuse treatment had been explained to the client and/or her family member prior to the implementation of the psychotropic medication.

W 124

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 that each

W 159

W159
For client #1, according to Ophthalmology visit on August 25, 2008, "Prescription for glasses given if patient is interested in having glasses."

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W 159	Continued From page 5 client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. The QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective for Client #1. [See W237] 2. The QMRP failed to coordinate services to ensure that Clients #1 and #3's eye glasses were available, and that strategies were developed and implemented to encourage them to wear them. [See W436]	W 159	According to Ophthalmology visit on June 29, 2010. "Vision/Ocular health good." LPN Coordinator will follow up with Ophthalmologist to determine need for continued use of glasses for client #1. For client #3, LPN Coordinator scheduled an appointment for 12/06/2010 for Ophthalmology assessment to obtain new prescription for glasses. Once new glasses are received for client #3 and if deemed necessary for client #1, nursing and the QMRP will provide training with staff on clients Health Maintenance Care Plan. This training will include appropriate documentation of encouragement and/or individual's refusal to wear glasses. Interdisciplinary team, including primary care physician and ophthalmologist, for clients #1 and #3 will discuss possible alternatives for impaired vision due to client's consistent refusal to wear glasses. During quarterly review, RN will document the status of adaptive equipment and ensure its appropriate use and function.	10/23/10	
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective, for one of three clients in the sample. (Client #1) The finding includes:	W 237			

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W 237 Continued From page 6
On September 21, 2010, at approximately 6:37 p.m., Client #1 was observed looking at the pages in a book.

On September 21, 2010, at 6:40 p.m., interview with direct care staff (DCS) revealed they sometimes took Client #1 to get books from the library to read, with staff assistance.

Record review on September 23, 2010, at 11:30 a.m., revealed an objective which stated, "Given physical assistance, [the client] will go to the library, select a Spanish tape, magazine or book of her choice/watch, read (with assistance) for 30 minutes, at 75% of trials for six consecutive months." Review of the data collection sheet on September 23, 2010, at 12:12 p.m., revealed the staff failed to document the number of minutes that the client watched a tape or read a book when she went to the library.

Interview with the Qualified Mental Retardation Professional (QMRP) on September 23, 2010 at 12:10 p.m., indicated that the client had not been able to accomplish the objective. The QMRP acknowledged during further discussion that the program data collection system was not designed to monitor the objective.

W 237 W237 10/23/10
For all clients, the Skill Acquisition Sheet will be modified to indicate client's progress on each task listed for all objectives. Client's refusal will be clearly indicated for each task. Program Director provided training with the QMRP on 10/18/10 on developing, implementing and evaluating Individual program plan goals. QMRP provided training with staff on proper documentation for data collection of client's IPP progress on 9/30/10. As a part of Quality Assurance, QMRP will monitor staff documentation monthly and indicate review of data in monthly QMRP notes.

W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

W 262

This STANDARD is not met as evidenced by:

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W 262 Continued From page 7

W 262 W262

10/23/10

Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for three of three clients in the sample. (Clients #1, #2, and #3)

The findings include:

1. Observations during the medication administration, on September 21, 2010, at 8:52 a.m., revealed that Client #1 received Luvox 50 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration, indicated that the client received the medication for maladaptive behaviors.

Interview with the qualified mental retardation professional (QMRP) and the review of Client #1's record on September 22, 2010, at approximately 11:20 a.m., revealed the client had a behavior support plan (BSP) to address her targeted behaviors. Further review of the BSP dated June 2010 confirmed that it addressed her maladaptive behaviors of property destruction, verbal aggression, making unfounded statement or false allegations, inappropriate sexual comments and/or behavior gestures, leaving staff supervision, agitation, self-injurious behavior, hallucinations and thought distortions. The review of the HRC minutes on September 22, 2010, beginning at 11:37 a.m., revealed that the HRC did not review the psychotropic medications.

2. On September 21, 2010, beginning at 9:45 a.m., during the entrance conference, the QMRP indicated that Client #2 had BSP and received psychotropic medications.

The HRC form was updated to include the review and approval of current psychotropic medications on 10/15/2010. HRC Chair, QMRP, and RN Supervisor will ensure all restrictive measures, including the use of prescribed psychotropic medications are approved during quarterly HRC meetings. HRC Chair will provide temporary approval for changes in restrictive controls during the interim periods. QMRP will provide quarterly review of restrictive controls.

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W 262 Continued From page 8 W 262

This was verified later that day at 1:17 p.m., while reviewing Client #2's physician orders dated September 1, 2010. The POS revealed Risperdal 3 mg and Paxil 20 mg were prescribed. Review of Client #2's BSP dated August 2010, on September 23, 2010, at approximately 10:00 a.m. confirmed the findings. Review of the HRC minutes on September 22, 2010, beginning at 11:37 a.m., however, revealed that the HRC had reviewed and approved Client #2's BSP on August 20, 2010, however did not review and/or approve the client's psychotropic medications.

3. Medication observations on September 21, 2010, at 8:46 a.m., revealed Client #3 receiving Klonopin 2 mg, Seroquel 300 mg, Cogentin 2 mg, and Depakote DR 500 mg. Interview with the LPN, after the medication administration indicated that the client received the aforementioned medication for anxiety and maladaptive behaviors.

Interview with the QMRP on September 22, 2010, at approximately 11:00 a.m., revealed Client #3 had a BSP to address her targeted behaviors. Review of the BSP dated July 2010, on September 22, 2010 at approximately 11:12 a.m. confirmed that the client had a current BSP to address her maladaptive behaviors of physical and verbal aggression, property destruction, agitation, etc.

Review of the client's physician orders on September 21, 2010, beginning at 10:50 a.m., revealed the following order: Depakote ER 500 mg, twice a day (BID), Cogentin 2 mg, BID, Haldol, injection 50 mg once a week, and Seroquel 300 mg, TID, and Klonopin 2 mg, TID. The LPN confirmed that the client received the

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W 262 Continued From page 9 following medications. W 262

The review of the HRC minutes on September 22, 2010, beginning at 11:37 a.m., revealed that the HRC reviewed and approved the client's BSP to include the following medications: Depakote ER 500 mg, twice a day (BID), Cogentin 2 mg, BID, Haldol 50 mg once a week, and Seroquel 200 mg, TID, and Klonopin 1 mg, TID. It should be noted that the client is currently receiving Seroquel 300 mg, TID and Klonopin 2 mg TID

The facility failed to review and approve the client's current psychotropic medications as prescribed.

W 312 483.450(e)(2) DRUG USAGE

Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

This STANDARD is not met as evidenced by. Based on observation, interview and record review, the facility failed to ensure drugs used to control inappropriate behavior were used only as an integral part of the client's individual program plan that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed, for one of the three clients included in the sample. (Client #1)

The finding includes:

1. Observations during the medication

W 312 W312

Client #1 Behavior Support Plan will be updated to include all current psychotropic medications. The Behavioral Specialist will ensure ongoing updates are reflected in the BSP. QMRP will review submitted BSP for accuracy. All prescribed medications and BSPs will be reviewed and approved quarterly during HRC meeting for accuracy.

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W 312	<p>Continued From page 10</p> <p>administration, on September 21, 2010, at 8:52 a.m., revealed that Client #1 received Seroquel 300 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration, indicated that the client received the medication for maladaptive behaviors.</p> <p>On September 22, 2010, at approximately 11:20 a.m., interview with the qualified mental retardation professional (QMRP) and the review of Client #1's record revealed the client had a behavior support plan (BSP) to address her targeted behaviors.</p> <p>On September 22, 2010, at approximately 11:32 a.m., review of the BSP dated June 2010 confirmed that it addressed her maladaptive behaviors of property destruction, verbal aggression, making unfounded statement or false allegations, inappropriate sexual comments and/or behavior gestures, leaving staff supervision, agitation, self-injurious behavior, hallucinations and thought distortions.</p> <p>On September 22, 2010, beginning at 11:37 a.m., review of the POS dated September 1, 2010, revealed that Client # 1 was prescribed Seroquel 300 mg , 1 tab by mouth each morning and Seroquel 400 mg, 3 tabs (1200 mg) daily at bedtime by mouth. At the time of the survey, there was no evidence that the behavior support plan included the use of the aforementioned medication.</p>	W 312	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p>	W 322	

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W 322 Continued From page 11

This STANDARD is not met as evidenced by:
Based on interview, and record review, the facility failed to ensure timely preventive health services, for one of the three clients in the sample. (Client #1)

The finding includes:

The facility failed to ensure that Client #1 received prescribed medication timely, as evidenced below:

Interview with the LPN on September 22, 2010 at 1:10 p.m. revealed the client was evaluated by the dentist on April 13, 2010, the day after she broke her tooth. At that time, the dentist recommended that the client return on May 6, 2010 to have a root canal on tooth #12.

Review of Client #1's medical records on September 23, 2010, at approximately 9:50 a.m., revealed a dental consult dated May 8, 2010, and that the dentist performed a root canal on tooth #12. The dentist prescribed Amoxicillin 500 mg, 20 tabs, 1 tab by mouth twice a day until finished and also Motrin 600 mg, 24 tabs, 1 tab every 6 hours. On September 23, 2010 at 3:43 p.m., further discussion with the LPN indicated that primary care physician (PCP) was notified of the dentist's findings and approved Client #1 to have the recommended medications.

The review of the medication administration record (MAR) on September 23, 2010, at 3:23 p.m., however, revealed Client #1 did not receive the first dosage of the antibiotic (Amoxicillin) until May 10, 2010, at 8:00 p.m.

W 322

W322
Prescribed medications will be received and administered within 24 hours of Primary Care Physician approval. ILS Program Director provided training with the LPN Coordinator and LPNs responsible for administering medications on timely implementation of physician recommendations, including transcribing, ordering, and administering new or adjusted medication regimens on 10/21/10. RN Supervisor will ensure compliance with policy during quarterly audit.

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W 322	Continued From page 12	W 322			
W 331	On September 23, 2010, at 3:57 p.m., the LPN acknowledged that the client did not receive the Amoxicillin until 4 days after it was prescribed. 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 observation, staff interviews and record review, the facility failed to provide each client with nursing services in accordance with their needs, for four of the six clients residing in the facility. (Clients #1, #3, #4, and #5) The findings include: 1. [Cross refer to W111]. The facility failed to ensure treatment records medication administration records were accurately maintained for Clients #3 and #5. 2. [Cross refer to W369]. The facility nursing services failed to ensure medications were administered without error for Client #4. 3. [Cross refer to W322]. The facility nursing services failed to ensure that Client #1 received prescribed medication timely.	W 331	W331 See W111, W322 and W369.	October 23, 2010.	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.	W 356			

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W 356	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely comprehensive services for the maintenance of dental health, for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Interview with the licensed practical nurse (LPN) on September 22, 2010 at 1:10 p.m., revealed the client was evaluated by the dentist on April 13, 2010, the day after she broke her tooth.</p> <p>Record review on September 22, 2010 at 5:25 p.m. revealed that on April 12, 2010, upon her arrival home from the day program, Client #1 told the nurse that her front tooth fell out. The statement sent home by the day program stated that some tooth was left in the gum. The dental consultation report dated April 13, 2010 stated client "presented to dentist office with tooth #9 fractured." The dentist recommended that the client return for a consultation on May 6, 2010 to have a root canal treatment on tooth #12.</p> <p>Continued record review on September 23, 2010 at approximately 9:40 a.m., revealed a nursing progress note dated April 19, 2010, which reported that the client had complained of pain on that morning, however, had a dental appointment scheduled.</p> <p>On September 23, 2010 at 9:50 a.m. review of a dental consultation report dated May 6, 2010, revealed the dentist performed a root canal on tooth #12.</p> <p>It was further noted that there was no mentioning</p>	W 356	<p>W356 Program Director provided training with the LPN Coordinator on 10/18/10 on reviewing consultation reports upon return from visit to ensure needs are addressed by provider. Training will also include timely follow up and implementation of physician recommendations. RN will provide quarterly QA to ensure future timely follow up of physician recommendation.</p> <p>Individual #1 was seen by dentist on 6/2/10 and tooth #9 crown was re-cemented. Prior authorization from DC Medicaid pending for partials.</p>

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W 356	Continued From page 14 of the fractured tooth #9 in the consultation report. There was however, no further information provided by the dentist on plan to address the fractured tooth.	W 356	
W 382	<p>483.460(j)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly for two of three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>Interview with the licensed practical nurse (LPN) on September 22, 2010 at 3:50 p.m., revealed the pharmacist should come to the facility every three months to conduct reviews of the clients' medications.</p> <p>The review of Clients #1 and #3's records on September 22, 2010, beginning at 3:57 p.m., revealed no pharmacy reviews were documented between July 9, 2009 and November 2, 2009. Further review of the medical records of the aforementioned clients also revealed that no pharmacy reviews were documented between February 2, 2010 and June 24, 2010.</p> <p>Continued discussion with the LPN on September 23, 2010 at 4:44 p.m., acknowledged that the pharmacist had not reviewed the clients' medication regimens quarterly as required.</p>	W 382	<p>W362</p> <p>ILS will establish a pharmacy visit schedule to ensure accessibility to residential facility and individual records for drug regimen reviews. ILS will ensure nursing staff availability during scheduled review. RN Supervisor will ensure compliance with policy during quarterly audit.</p> <p>10/23/10</p>
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369	

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W 369 Continued From page 15

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by: Based on observation, client and staff interviews and record verification, the facility's nursing staff failed to ensure that all drugs were administered without error, for one of the six clients residing in the facility. (Client #4)

The finding includes:

On September 21, 2010, at 7:25 a.m., the surveyor entered the facility. Interview with Client #4 at 7:55 a.m., revealed that she had breakfast and it consisted of cream of wheat, bacon and toast. Further interview revealed that she had completed her fingerstick and the reading was 95.

At 8:05 a.m., the licensed practical nurse (LPN) was observed entering the facility. Interview with the LPN at 8:10 a.m., revealed that she would be administering the morning medications to the clients. At 8:12 a.m., Client #4 was observed preparing her medications with physical assistance from the LPN. The client consumed Reglan 5 mg. Interview with the medication nurse indicated that the Reglan was prescribed for reflux prevention. Review and reconciliation of the physician orders (POS) on September 21, 2010, at 9:40 a.m., confirmed that Client #4 was prescribed Reglan 5 mg, four times a day, before meals.

Interview with the LPN Coordinator on September 21, 2010, at 9:45 a.m., revealed that Client #4

W 369 W369

Disciplinary action in the form of a written warning was issued to the LPN identified as previously trained but failing to adhere to the Medication Administration Policy and Procedures. To prevent future occurrence of delay in medication administration, the LPN responsible for administering medications will contact the LPN Coordinator immediately. LPN Coordinator will ensure medications are administered on time. See also W111.

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W 369	Continued From page 16	W 369		
	should have received Reglan 5 mg. before meals.			
W 391	483.460(m)(2)(ii) DRUG LABELING	W 391	W391	10/23/10
	<p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility's nurse failed to remove medications with no labels from use, for one of the six clients residing in the facility. (Client #6)</p> <p>The finding includes:</p> <p>During the medication observations on September 21, 2010, at 8:32 a.m., the licensed practical nurse (LPN) removed a blister package containing pills from a vinyl sleeve. Seconds later, the LPN administered the medication to Client #6. The blister package read, "TriSprintec oral contraceptive." Further observations revealed no evidence of a client's name, dosage or instructions on the medication blister package. The package was distributed by the pharmaceutical company.</p> <p>Interview with the LPN, after the medication administration, acknowledged that the blister package had no label. However, the medication belonged to Client #6. Further interview revealed should would call the pharmacist and a new label would be dispensed.</p> <p>Review of Client #6's physician's orders dated September 2010, at 9:30 a.m., revealed an order for TriSprintec oral contraceptive once a day.</p> <p>At the time of the survey, there was no evidence</p>		<p>Program Director provided training on 10/18/10 with the LPN Coordinator on checking medications received from the pharmacy for a label indicating the right client, right medication, right dose, right schedule and right amount and compare to the physician order sheets for accuracy. The LPN Coordinator will immediately inform the pharmacist when inaccuracies are identified. RN Supervisor will ensure compliance with policy during quarterly audit.</p>	

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W 391	Continued From page 17 that the facility had removed the unlabeled medication for use.	W 391		
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W 418	<p>483.470(b)(4)(ii) CLIENT BEDROOMS</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client in the facility was provided with a comfortable mattress, for one of the six clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On September 23, 2010, at 1:29 p.m., the residential director (RD) accompanied the surveyor through the facility to conduct environmental observations. At 1:42 p.m., multiple palpable springs were felt on the surface of the mattress on Client #4's bed, when it was touched.</p> <p>At approximately 1:44 p.m. on September 23, 2010, the RD checked Client #4's mattress and acknowledged that the springs were palpable.</p> <p>There was no evidence that the mattress on Client #4's bed would ensure her comfort when sitting or lying on it.</p>	W 418	<p>W418</p> <p>Client #4 mattress was replaced on 10/1/10. House manager will conduct monthly environmental checks within the residential facility and identify issues that may compromise the comfort of all individuals. The issues will be escalated to the QMRP and/or Program Director for intervention when necessary.</p>	10/23/10
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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>	W 436		
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W 436	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the consistent use and maintenance of assistive devices as recommended, for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure Client #1 had eyeglasses as recommended by the interdisciplinary team, and received training to care for them, as evidenced below: Observation of Client #1 at her day program on September 21, 2010 at 1:59 p.m., revealed her standing closely to a survival signs chart, which was located at the front of the classroom. During this time, the client required verbal prompts from the instructor to identify some of the signs. According to the instructor, she had worn glasses in the past, however, no longer wore them. Interview with a direct care staff on September 22, 2010 at 10:39 a.m., revealed that Client #1 had eyeglasses in the past, however, she had never seen them. Interview with the qualified mental retardation professional (QMRP) indicated that she had never seen the client's glasses. According to the licensed practical nurse (LPN), the client did not like to wear glasses, and had broken them approximately five months prior to the survey. On September 23, 2010, at 9:55 a.m., a quarterly nursing progress note dated April 8, 2010,	W 436	W436 See W159.	October 23, 2010.

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W 436	<p>Continued From page 19</p> <p>revealed the client had eye glasses and refused to wear them, and should be encouraged to wear them. The individual support plan (ISP) dated June 22, 2010, revealed the client should have eye glasses. On September 23, 2010 at 10:20 a.m., the physician's orders dated September 1, 2010, revealed, "Adaptive equipment - eye glasses."</p> <p>At the time of the survey, there was no evidence that the facility had ensured that Client #1's eyeglasses were available and that strategies were developed to encourage her to wear them.</p> <p>2. Review of Client #3's medical record on September 21, 2010, beginning at 10:50 a.m., revealed a diagnosis of Best Disease. Interview with the LPN on September 21, 2010, at approximately 2:00 p.m., revealed that Best Disease is a form of progressive macular dystrophy, located in the center of the retina, at the back of the eye where there is a concentration of cone cells. Further record review on the same day, at approximately 2:30 p.m., revealed an ophthalmology consult dated October 15, 2009. The consult confirmed the diagnosis and that unfortunately no treatment exists. However, vision should be maximized by wearing eyeglasses and an annual eye exam.</p> <p>Interview with Client #3 on September 21, 2010, at 4:30 p.m., indicated that she had a pair of eyeglasses but does not like to wear them. She also reported that she broke the eyeglasses, sometime ago. Interview with the residential director (RD) on September 22, 2010, at approximately 4:00 p.m., revealed that since she started working at the facility (July 2010), she had not seen Client #3 with a pair of eyeglasses.</p>	W 436		
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W 436	Continued From page 20 Interview with the QMRP on September 22, 2010, at approximately 4:30 p.m., revealed that the client broke her eyeglasses about four months ago.	W 436		
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	Review of Client #3's individual program plan (IPP) dated July 24, 2010, on September 22, 2010, at approximately 12:41 p.m., revealed no evidence of a training program to teach Client #3 to tolerate her eyeglasses or make an informed choice on wearing them.			
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W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441	W441 The QMRP provided training on 9/30/10 with the House Manager and staff on conducting fire drills under varied conditions and using all exits each month.	10/23/10
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	This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)		The fire drill schedule and form has been updated to include all exit options. House Manager will check fire drills monthly to ensure compliance.	
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	The finding includes:			
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	On September 21, 2010, at 10:12 a.m., review of the facility's fire drill records revealed that most of the fire drills were conducted utilizing the front and back door exits. Interview with the residential director (RD) on the same day at approximately 11:06 a.m., revealed that the facility had at least four method of egress (front door, back door, side rear door, and basement door). Further review of the fire drill records revealed that the side rear door and basement door exit had not been used. There was no evidence on file at the time of survey to substantiate that all exits were used.			
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W 454	483.470(i)(1) INFECTION CONTROL	W 454		
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(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 454	Continued From page 21	W 454	W454	10/23/10
	The facility must provide a sanitary environment to avoid sources and transmission of infections.		The QMRP provided training on 9/30/10 with the House Manager and staff on maintaining sanitary conditions at all times within the facility. The LPN Coordinator will provide training with staff on infection control. When blood or bodily fluids are exposed, staff and clients will ensure facility restrooms and hard surfaces are wiped off using antimicrobial soap and/or disinfectant following use. Nursing will provide ongoing training to ensure compliance. House Manager and QMRP will monitor to ensure compliance in the future.	
	This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure sanitary conditions at all times, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)			
	The finding includes:			
	On September, 21, 2010, at approximately 10:45 a.m., while using the bathroom located on the main level of the facility, blood was observed underneath the toilet seat. A few minutes later at approximately 10:50 a.m., the qualified mental retardation professional (QMRP) immediately inspected the toilet seat, then directed staff to clean the blood from underneath the toilet seat. There was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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1 000 INITIAL COMMENTS

1 000

An licensure survey was conducted on September 21, 2010, through September 23, 2010. A random sample of three residents was selected from a population of six females with various levels of mental retardation and disabilities.

The findings of the survey were based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
11-24-10**

1 060 3502.18 MEAL SERVICE / DINING AREAS

1 060

1060

10/23/10

Perishable foods shall be stored at proper temperatures in order to conserve nutritive value.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to perishable foods were stored at the proper temperature, for six of the six residents residing in the GHMRP. (Residents #1, #2, #3, #4, #5, and #6)

The findings include:

On September 22, 2010, at 10:35 a.m., a package of frozen chicken wings and frozen mixed fruit were observed on the kitchen counter. During the environmental inspection at approximately 2:30 p.m., the residential director (RD) was observed placing the chicken and mixed fruit in the refrigerator. At approximately 4:30 p.m., the direct care staff was observed preparing chicken for the residents' dinner.

QMRP provided training with staff of food and safety and proper handling on 9/30/10. QMRP will ensure food is properly stored and prepared to prevent the potential growth of food borne organisms. Nursing will provide ongoing training to ensure compliance. House Manager and QMRP will monitor to ensure compliance in the future.

Health Regulation Administration

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

TITLE

(X6) DATE

STATE FORM

3599

GX1D11

If continuation sheet 1 of 25

Executive Director 11/27/10

Health Regulation Administration

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I 060	Continued From page 1 On September 23, 2010, at 10:48 a.m., a family package of frozen chicken thighs was observed on the kitchen counter. At 12:30 p.m., the direct care staff was observed placing the chicken in the refrigerator. Review of the menu for September 22, 2010, at approximately 1:00 p.m., revealed that chicken was on the menu for those days. Interview with the RD on September 23, 2010, at approximately 3:00 p.m., indicated that the meat should have been removed from the freezer and placed in the refrigerator to thaw. There was no evidence the GHMRP exercised safe handling procedures to prevent the potential growth of food borne organisms.	I 060		
I 090	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, interview, record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to maintain the physical environment, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: During the environmental inspection on September 23, 2010, beginning at 1:20 p.m., the following concerns were identified: 1. There was no protective covering (globe) for	I 090	I090 ILS retains a service contractor for ongoing maintenance and to address the identified potential trip hazards and risk for infection and infestation. ILS will ensure maintenance contractor provides monthly monitoring of residential facility interior and exterior environment. See also W418 and W454. ILS has ensured environmental repairs have been addressed. 1.) Fixed on 10/1/10.	10/23/10

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1090	<p>Continued From page 2</p> <p>the light bulb in the light fixture, which was located at the upper right corner of the basement entrance door, at the rear of the facility.</p> <p>2. A hole, approximately five inches in diameter, was observed in the paved walkway beside the ramp at the rear of the facility. The hole created a potential trip hazard.</p> <p>3. Broken and uneven pavement were also observed in the back yard in the following areas:</p> <p>a. On the walkway at the rear of the facility, a section of the pavement was observed to be uneven, with one section being approximately an inch higher than the adjoining section.</p> <p>b. A long crack, which was approximately three feet by one inch wide, was observed on the walkway.</p> <p>c. A large area of broken and uneven pavement was observed in front of the grill.</p> <p>These areas of uneven and cracked pavement created potential trip hazards.</p> <p>5. A rotting trip stump, which was approximately fourteen inches tall, was observed on the left side of the ramp in the back yard. This created a potential for infestation by wood digesting pests.</p> <p>6. When walking on the ramp, movement was detected on several of the floor boards. The ramp was observed to begin at the exit door from the bedroom of Residents #4 and #5. Discussion with the administrator on September 23, 2010, indicated that none of the residents currently residing in the facility required the use of the ramp as an exit.</p>	1090	<p>2.) Fixed on 11/1/10.</p> <p>3.) Completed on 11/5/10 and 11/6/10.</p> <p>5.) Stump was cut down to make level with ground to remove any safety hazards on 11/15/10.</p> <p>6.) Fixed on 11/15/10.</p> <p>7.) Corrected on 10/29/10.</p> <p>8.) Fixed on 10/29/10.</p> <p>9.) Part was ordered and is scheduled for repair between 11/22 -11/25/10.</p> <p>10.) Replaced on 10/1/10.</p> <p>11.) Program Director completed training with House Manager on 10/18/10 on environmental rounds and reporting. See also W454.</p>

Health Regulation Administration

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1090 Continued From page 3

1090

7. Observation of the closet door in the bedroom of Residents #4 and #5 revealed opening of the door was obstructed. There was not enough space between the door and a bed for it to open completely. The Residential Director (RD) indicated that the bi-fold closet door had been modified to open as a single door. There was no evidence the facility ensured the positioning of the bed allowed the Residents easy access to their belongings stored in the closet.

8. No source of natural or mechanical ventilation was observed in the basement bathroom. Interview with the RD indicated that the window located in the basement bathroom did not open.

9. The bottom section of the gasket on the interior of the oven door was missing. Additionally, the gasket was detached on both the left and right side of the oven door. These created the potential for heat to escape during cooking, and for an increased cooking time.

10. Multiple palpable springs were felt on the surface of the mattress on Resident #4's bed, when it was touched. The RD checked Resident #4's mattress and confirmed the finding. There was no evidence that the mattress on Resident #4's bed would ensure her comfort when sitting or lying on it.

The aforementioned concerns were acknowledged by the RD and the qualified mental retardation professional (QMRP) during the survey.

11. The GHMRP failed to ensure sanitary conditions at all times, for six of six residents residing in the facility.

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I 090	Continued From page 4 On September, 21, 2010, at approximately 10:45 a.m., while using the bathroom located on the main level of the facility, blood was observed underneath the toilet seat. Upon notification, the QMRP immediately inspected the toilet seat, then directed staff to clean the blood from underneath the toilet seat. There was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on the interview and review of the fire drill records, the Group Home for Mentally Retarded Persons (GHMRP) failed to conduct fire drills under varied conditions, for six of six residents residing in the GHMRP. (Residents #1, #2, #3, #4, #5, and #6) The finding includes: On September 21, 2010, at 10:12 a.m., review of the GHMRP's fire drill records revealed that most of the fire drills were conducted utilizing the front and back door exits. Interview with the residential director (RD) on the same day at approximately 11:06 a.m., revealed that the GHMRP had at least four method of egress (front door, back door, side rear door, and basement door). Further review of the fire drill records revealed that the side rear door and basement door exit had not been used. There was no evidence on file at the time of survey to substantiate that all	I 135	I135 See W441.	October 23, 2010.

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I 135	Continued From page 5 exits were used.	I 135		
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that each resident's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for two of three residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective for Resident #1. [See Citation 1420] 2. The QMRP failed to coordinate services to ensure that Residents #1 and #3's eye glasses were available, and that strategies were developed and implemented to encourage them to wear them. <p>a. Observation of Resident #1 at her day program on September 21, 2010 at 1:59 p.m., revealed her standing closely to a survival signs chart, which was located at the front of the classroom. During this time, the resident required verbal prompts from the instructor to identify some of</p>	I 180	I180 See W159.	October 23, 2010.

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1180 Continued From page 6

1180

the signs. According to the instructor, she had worn glasses in the past, however, no longer wore them.

Interview with a direct care staff on September 22, 2010 at 10:39 a.m., revealed that Resident #1 had eyeglasses in the past, however, she had never seen them. Interview with the qualified mental retardation professional (QMRP) indicated that she also had never seen the resident's glasses. According to the licensed practical nurse (LPN), the resident did not like to wear glasses, and had broken them approximately five months prior to the survey.

On September 23, 2010, at 9:55 a.m., a quarterly nursing progress note dated April 8, 2010, revealed the resident had eye glasses and refused to wear them, and should be encouraged to wear them. The individual support plan (ISP) dated June 22, 2010, revealed the resident should have eye glasses. On September 23, 2010 at 10:20 a.m., the physician's orders dated September 1, 2010, revealed, "Adaptive equipment - eye glasses."

At the time of the survey, there was no evidence that the facility had ensured that Resident #1's eyeglasses were available and that strategies were developed to encourage her to wear them.

b. Review of Resident #3's medical record on September 21, 2010, beginning at 10:50 a.m., revealed a diagnosis of Best Disease. Interview with the LPN on September 21, 2010, at approximately 2:00 p.m., revealed that Best Disease is a form of progressive macular dystrophy, located in the center of the retina, at the back of the eye where there is a concentration of cone cells. Further record

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I 180 Continued From page 7 | 180

review on the same day, at approximately 2:30 p.m., revealed an ophthalmology consult dated October 15, 2009. The consult confirmed the diagnosis and that unfortunately no treatment exists. However, vision should be maximized by wearing eyeglasses and an annual eye exam.

Interview with Resident #3 on September 21, 2010, at 4:30 p.m., indicated that she had a pair of eyeglasses but does not like to wear them. She also reported that she broke the eyeglasses, sometime ago. Interview with the residential director (RD) on September 22, 2010, at approximately 4:00 p.m., revealed that since she started working at the facility (July 2010), she had not seen Resident #3 with a pair of eyeglasses. Interview with the QMRP on September 22, 2010, at approximately 4:30 p.m., revealed that the resident broke her eyeglasses about four months ago.

Review of Resident #3's individual program plan (IPP) dated July 24, 2010, on September 22, 2010, at approximately 12:41 p.m., revealed no evidence of a training program to teach Resident #3 to tolerate her eyeglasses or make an informed choice on wearing them.

I 206 3509.6 PERSONNEL POLICIES | 206

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.

Health Regulation Administration

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I 206	Continued From page 8 This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure five of sixteen consultants and two of sixteen staff had current health certificates. The finding includes: On September 23, 2010, 11:30 a.m., interview with the residential director (RD) and review of the personnel records revealed the GHMRP failed to have evidence of current health certificates for five of sixteen consultants and two of sixteen staff.	I 206	I206 Program Director will provide training with the Human Resource Manager and the Training and Development Specialist on maintaining employee and consultant personnel files. All employees and consultants will have current health certificates on file. ILS will provide additional administrative support to monitor and tract all employee and consultant credentials.	10/23/10
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) primary care physician failed to sign physician orders (POS), for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. Reconciliation of the medication observation in comparison to the medication administration revealed no evidence that Residents #1, #2, #3, #4, #5, and #6's September 2010, POS were signed. Further review revealed that the clients POS dated August 2010, were signed on August 16, 2010. Interview with the licensed practical nurse (LPN)	I 291	I291 ILS has updated the Medication Administration Policy and Procedures to include obtaining prescribing physician signature within 24 hours for verbal / telephone orders and within 30 days for monthly orders. RN Supervisor will ensure compliance with policy during quarterly audit.	10/23/10

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I 291	Continued From page 9 on September 21, 2010, at approximately 2:40 p.m., indicated that the primary care physician comes once a month and is expected to come later this month. Review of the facility's policy on September 22, 2010, at approximately 10:00 a.m., revealed no evidence of a policy on when the primary care physician should sign POS. 2. Review of Resident #3's medical record on September 21, 2010, beginning at 10:50 a.m., revealed a telephone order dated August 30, 2010. Further review revealed that the order did not have a co-signature by the prescribing physician. Review of the facility's policy on September 22, 2010, at approximately 10:00 a.m., revealed no evidence of a policy on when the primary care physician should sign telephone orders.	I 291		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure professional services included treatment services, and services designed to prevent deterioration or further loss of function by the residents, for six of the six residents in the GHMRP. (Residents #1, #2, #3, #4, #5, and #6)	I 401	I401 See W111, W356, and W369.	October 23, 2010.

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I 401	Continued From page 10	I 401		
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The findings include:

1. The GHMRP failed to ensure that Resident #1 received medication timely, as prescribed as evidenced below:

Interview with the licensed practical nurse (LPN) on September 22, 2010 at 1:10 p.m. revealed the resident was evaluated by the dentist on April 13, 2010, the day after she broke her tooth. Further discussion with the LPN on September 22, 2010 at 2:33 p.m. revealed that Resident #3's day program reported she broke a tooth eating something. The resident was given a follow-up dental appointment for May 6, 2010.

The dentist recommended that the resident return for a consultation on May 6, 2010 have a root canal treatment on tooth #12. There was however, no further information provided by the dentist on plan to address the fractured tooth #9.

Continued record review on September 23, 2010 at approximately 9:40 a.m., revealed a nursing progress note dated April 19, 2010, which reported that the resident had complained of pain on that morning, however, had an appointment scheduled.

On September 23, 200 at 9:50 a.m., review of a dental consultation report dated May 6, 2010, revealed the dentist performed a root canal on tooth #12. The dentist prescribed Amoxicillin 500 mg, #20, 1 tab po BID until finished and also Motrin 600 mg, #24, 1 tab Q 6 hours. On September 23, 2010 at 3:43 p.m., further discussion with the LPN indicated that PCP was notified of the dentist's findings and recommendations and approved Resident #1 to have the medications.

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I 401 Continued From page 11 I 401

The review of the medication administration record (MAR) on September 23, 2010, at 3:23 p.m., however, revealed Resident #1 did not receive the first dosage of the antibiotic until May 10, 2010, at 8:00 p.m.

On September 23, 2010, at 3:43 p.m., the LPN confirmed that the resident did not receive the Amoxicillin until 4 days after it was prescribed.

2. The GHMRP failed to ensure a timely comprehensive services for the maintenance of dental health of one of three residents in the sample. (Resident #1)

Interview with the LPN on September 22, 2010, at 1:10 p.m., revealed the resident was evaluated by the dentist on April 13, 2010, the day after she broke her tooth.

Record review on September 22, 2010 at 5:25 p.m. revealed that on April 12, 2010, upon her arrival home from the day program, Resident #1 told the nurse that her front tooth fell out. The statement sent home by the day program stated that some tooth was left in the gum. The dental consultation report dated April 13, 2010 stated resident "presented to dentist office with tooth #9 fractured." The dentist recommended that the resident return for a consultation on May 6, 2010 to have a root canal treatment on tooth #12.

Continued record review on September 23, 2010 at approximately 9:40 a.m., revealed a nursing progress note dated April 19, 2010, which reported that the resident had complained of pain on that morning, however, had a dental appointment scheduled.

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I 401 Continued From page 12 I 401

On September 23, 2010 at 9:50 a.m., review of a dental consultation report dated May 6, 2010, revealed the dentist performed a root canal on tooth #12.

It was further noted that there was no mentioning of the fractured tooth #9 in the consultation report. There was however, no further information provided by the dentist on plan to address the fractured tooth.

3. The GHMRP failed to ensure treatment records medication administration records were accurately maintained for Residents #3 and #5.

a. Observation of the medication administration on September 21, 2010, at 8:46 a.m., revealed Resident #3 received Klonopin 2 mg, Therobec Plus, Seroquel 300 mg, Cogentin 2 mg, Topamax 100 mg, Depakote DR 500 mg, Calcium 600/D400 and artificial tear drops. Review of the MAR on September 21, 2010 at 9:35 a.m., revealed that the resident was to receive Bactrim DC, however, the resident did not receive the Bactrim.

Review of Resident #3's physician orders (POS) dated September 2010, after the medication administration, revealed an order for Bactrim DC, one tablet, twice a day for 10 days, for cellulitis of right deltoid. Further review of the MAR indicated that the resident began receiving the medication on the morning of September 1, 2010 through September 21, 2010 (totaling 21 doses). Interview with the medication nurse indicated that the documentation was an oversight.

b. Reconciliation of Resident #5's medication with the POS and MARs on September 21, 2010, at 9:30 a.m., revealed that Fluticasone 50 mcg

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1401	<p>Continued From page 13</p> <p>nasal spray, one to two sprays, twice a day was prescribed for one week. Further review of the MARs revealed the medication had been signed off as given on September 21, 2010, however, was not administered. Continued review of the MARs also revealed that the nasal spray began on September 9, 2010, (in the morning) and ended on September 21, 2010.</p> <p>c. Observation during the medication administration on September 21, 2010, at 8:20 a.m., revealed Resident #5 punching Triam/HCTZ 37.5 mg tablet from a bubble package, with assistance from the medication nurse. Reconciliation of Resident #5's medication observation with the POS and MARs on September 21, 2010, at 9:30 a.m., revealed that Trim/HCTZ 37.5 mg tablet was prescribed on September 1, 2010. According to the September 2010 MARs, the Trim/HCTZ 37.5 mg tablet was not signed by the medication nurse for the entire month of September 2010. Interview with the medication nurse indicated that it was an oversight. She further indicated that all medications administered should be signed by the licensed personnel who administers them.</p> <p>4. The GHMRP failed to ensure medications were administered without error for Resident #4.</p> <p>On September 21, 2010, at 7:25 a.m., the surveyor entered the GHMRP. Interview with Resident #4 at 7:55 a.m., revealed that she had breakfast and it consisted of cream of wheat, bacon and toast. Further interview revealed that she had completed her fingerstick and the reading was 95.</p> <p>At 8:05 a.m., the LPN was observed entering the GHMRP. Interview with the LPN at 8:10 a.m.,</p>	1401	

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1401	<p>Continued From page 14</p> <p>revealed that she would be administering the morning medications to the residents. At 8:12 a.m., Resident #4 was observed preparing her medications with physical assistance from the LPN. The resident consumed Reglan 5 mg. Interview with the medication nurse indicated that the Reglan was prescribed for reflux prevention. Review and reconciliation of the physician orders (POS) on September 21, 2010, at 9:40 a.m., confirmed that Resident #4 was prescribed Reglan 5 mg, four times a day, before meals.</p> <p>Interview with the LPN Coordinator on September 21, 2010, at 9:45 a.m., revealed that Resident #4 should have received Reglan 5 mg, before meals.</p>	1401		
1407	<p>3520.9 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that drug regimen reviews were conducted at least quarterly for two of three residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>Interview with the licensed practical nurse (LPN) on September 22, 2010 at 3:50 p.m., revealed the pharmacist should come to the facility every three months to conduct reviews of the residents' medications.</p> <p>The review of Residents #1 and #3's records on</p>	1407	1407 See W362.	October 23, 2010.

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I 407 Continued From page 15
September 22, 2010, beginning at 3:57 p.m., revealed no pharmacy reviews were documented between July 9, 2009 and November 2, 2009. Further review of the medical records of the aforementioned residents also revealed that no pharmacy reviews were documented between February 2, 2010 and June 24, 2010.

Continued discussion with the LPN on September 23, 2010 at 4:44 p.m., acknowledged that the pharmacist had not reviewed the residents' medication regimens quarterly as required.

I 407

I 420 3521.1 HABILITATION AND TRAINING

Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.

This Statute is not met as evidenced by:
Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure each resident received training to effectively cope with the demands of the environment, for one of three residents in the sample. (Resident #1)

The finding includes:

The GHMRP failed to ensure that Resident #1's written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the objective, as evidenced below:

On September 21, 2010, at approximately 6:37

I 420

I420
See W237.

October 23, 2010.

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I 420	<p>Continued From page 16</p> <p>p.m., Resident #1 was observed looking at the pages in a book.</p> <p>On September 21, 2010, at 6:40 p.m., interview with direct care staff (DCS) revealed they sometimes took Resident #1 to get books from the library to read, with staff assistance.</p> <p>Record review on September 23, 2010, at 11:30 a.m., revealed an objective which stated, "Given physical assistance, [the resident] will go to the library, select a Spanish tape, magazine or book of her choice/watch, read (with assistance) for 30 minutes, at 75% of trials for six consecutive months." Review of the data collection sheet on September 23, 2010, at 12:12 p.m., revealed the staff failed to document the number of minutes that the resident watched a tape or read a book when she went to the library.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on September 23, 2010 at 12:10 p.m., indicated that the resident had not been able to accomplish the objective. The QMRP acknowledged during further discussion that the program data collection system was not designed to monitor the objective.</p>	I 420		
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I 473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident 's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group for Mentally Retarded Persons (GHMRP) failed to report any irregularities to the Primary Care Physician (PCP), for one of the six residents residing in the GHMRP. (Resident #4)</p>	I 473	<p>1473 See W111 and W369.</p>	<p>October 23, 2010.</p>
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1473	<p>Continued From page 17</p> <p>The finding includes:</p> <p>On September 21, 2010, at 7:25 a.m., the surveyor entered the GHMRP. Interview with Resident #4 at 7:55 a.m., revealed that she had breakfast and it consisted of cream of wheat, bacon and toast. Further interview revealed that she had completed her fingerstick and the reading was 95.</p> <p>At 8:05 a.m., the licensed practical nurse (LPN) was observed entering the GHMRP. Interview with the LPN at 8:10 a.m., revealed that she would be administering the morning medications to the residents. At 8:12 a.m., Resident #4 was observed preparing her medications with physical assistance from the LPN. The resident consumed Reglan 5 mg. Interview with the medication nurse indicated that the Reglan was prescribed for reflux prevention. Review and reconciliation of the physician orders (POS) on September 21, 2010, at 9:40 a.m., confirmed that Resident #4 was prescribed Reglan 5 mg, four times a day, before meals.</p> <p>Interview with the LPN Coordinator on September 21, 2010, at 9:45 a.m., revealed that Resident #4 should have received Reglan 5 mg, before meals.</p>	1473		
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1474	<p>3522.5 MEDICATIONS</p> <p>Each GHMRP shall maintain an individual medication administration record for each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure medication</p>	1474	<p>1474 See W111.</p>	<p>October 23, 2010.</p>
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I 474 Continued From page 18
administration records (MARs) were maintained, for two of the six residents residing in the GHMRP.
(Residents #3 and #5)

The findings include:

[Cross refer to I401.3] The GHMRP failed to ensure each resident's medication administration records (MAR) was accurately maintained.

I 474

I 484 3522.11 MEDICATIONS

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.

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) nurse failed to remove medications with missing labels from use, for one of the six residents residing in the facility.
(Resident #6)

The finding includes:

During the medication observations on September 21, 2010, at 8:32 a.m., the licensed practical nurse (LPN) removed a blister package containing pills from a vinyl sleeve. Seconds later, the LPN administered the medication to Resident #6. The blister package read, "TriSprintec oral contraceptive." Further observations revealed no evidence of a resident's name, dosage or instructions on the medication blister package. The package was distributed by the pharmaceutical company.

I 484

I484
See W391.

October 23, 2010.

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I 484	<p>Continued From page 19</p> <p>Interview with the LPN, after the medication administration, acknowledged that the blister package had no label. However, the medication belonged to Resident #6. Further interview revealed should would call the pharmacist and a new label would be dispensed.</p> <p>Review of Resident #6's physician's orders dated September 2010, at 9:30 a.m., revealed an order for TriSprintec oral contraceptive once a day.</p> <p>At the time of the survey, there was no evidence that the facility had removed the unlabeled medication for use.</p>	I 484		
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I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retardation Persons (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws, for two of three residents included in the sample. (Residents #2 and #3)</p> <p>The findings include:</p> <p>1. Observations during the medication administration, on September 21, 2010, at 8:52 a.m., revealed that Resident #1 received Fluvoxamine 50 mg (Luvox). Interview with the</p>	I 500	<p>1500</p> <p>Program Director provided training with LPN Coordinator on 10/18/10 on ensuring compliance with physician order sheets and medical records. ILS will coordinate with pharmacist to include expiration date of no more than 30 days for all psychotropic medications prescribed. See also W124 and W262. RN Supervisor will ensure compliance with policy during quarterly audit.</p>	10/23/10
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1500	<p>Continued From page 20</p> <p>Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received the medication for her maladaptive behaviors.</p> <p>Review of the resident's current physician orders (POs) dated September 2010, on September 21, 2010, at approximately 3:35 p.m., confirmed the aforementioned medication. Further review of the POs revealed an initial order date of February 6, 2010 for the Luvox 50 mg.</p> <p>Review of Resident #1's Psychological Assessment dated June 13, 2010, on September 22, 2010, at approximately 11:01 a.m., revealed that the resident was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the medications.</p> <p>The GHMRP failed to provide evidence that the potential risks involved in using this medication, or her right to refuse treatment had been explained to the resident and/or her family member until after the medication was prescribed then administered.</p> <p>2. The GHMRP failed to provide evidence that informed consent was obtained from Resident #3's family member for psychotropic medications as evidenced below:</p> <p>Observations during the medication administration, on September 21, 2010, at 8:46 a.m., revealed that Resident #3 received Klonopin 2 mg, Seroquel 300 mg, Cogentin 2 mg, and Depakote DR 500 mg. Interview with the</p>	1500	

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I 500	<p>Continued From page 21</p> <p>Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received the aforementioned medication for anxiety and maladaptive behaviors.</p> <p>Review of the resident's current physician orders dated September 2010, on September 21, 2010, at approximately 10:50 a.m., confirmed the aforementioned medications. In addition, the resident was ordered Haloperidol injection, 50 mg every seven days for combative aggressive behavior.</p> <p>Review of Resident #3's Psychological Assessment dated July 24, 2009, on September 21, 2010, at approximately 3:00 p.m., revealed that the resident was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the medications.</p> <p>The GHMRP failed to provide evidence that the potential risks involved in using this medication, or her right to refuse treatment had been explained to the resident and/or her family member, prior to the implementation of the psychotropic medication.</p> <p>3. The GHMRP failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for three of three resident in the sample. (Residents #1, #2, and #3) [See Federal Deficiency Report - Citation W262]</p> <p>4. 7-1305.05 (h) "No medication shall be administered unless at the written or verbal order of a licensed physician, noted promptly in the</p>	I 500	

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I 999 Continued From page 23

I 999 FINAL OBSERVATIONS

The following observations were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent a potential non-compliant practice:

a. On September 21, 2010 at 1:42 p.m., observations at Resident #1's day program revealed her instructor pulling up her jeans, and pulling down her shirt to cover her back and red underwear, which were exposed when she stood up to answer a question.

Observation on September 21, 2010 at 4:25 p.m., revealed Resident #1 seated at the dining table. During this time, the waist of the resident's "low-rider" jeans exposed the crevice between her hips. At 4:31 p.m., the residential director asked the resident where her belt was, and instructed her to pull up her pants.

b. Observation on September 21, 2010 at 6:37 p.m., revealed Resident #6 seated at the dining table eating her evening meal. During this time, the waist of the resident's low-rider jeans exposed the crevice between her buttocks. Further observation revealed the crevice between her buttocks was again exposed as she leaned over at the kitchen sink. At 6:39 p.m., a DCS then asked the resident to pull up her pants.

Interview with staff on September 21, 2010 at 6:44 p.m. revealed that both residents owned a belt.

At the time of the survey, however, there was no evidence the GHMRP ensured that Residents #1 and #6 wore clothing accessories to ensure their

I 999

I 999

I 999

The QMRP provided training with staff on dressing clients appropriately for size, season and situation on 9/30/10. House Manager will ensure clothes fit appropriately or are tailored and/or replaced as needed. QMRP and House Manager will monitor to ensure compliance.

10/23/10

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1999	Continued From page 24 jeans remained in the appropriate position on the bodies to prevent undue exposure.	1999	