

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from June 20, 2012, through June 22, 2012. A sampling of three clients was selected from a population of six clients with varying degrees of intellectual disabilities. The survey was initiated utilizing the fundamental process.

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

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 104 483.410(a)(1) GOVERNING BODY

W 104

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the governing body failed to exercise general operating direction to address the needs of one of three clients in the sample. (Client #3)

The finding includes:

The facility failed to ensure the physical environment addressed the mobility needs of Client #3.

On June 21, 2012, at 7:36 a.m., Client #3 was observed to require maximum assistance from a

Received 7/20/12

**Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002**

Client #3's wheelchair has been assessed and is scheduled for repair follow up from NRH for the missing left tipper and left brake. The necessary parts have been ordered by the vendor and repairs will be completed by ... 7-30-12

Client #3 will continue to use the loaner chair in the interim. Family Home Medical has been requested to obtain a loaner chair with longer leg rests for client #3sw ... 7-16-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Ande Beahm</i>	<i>Program Director</i>	<i>07/17/2012</i>

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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one on one staff to walk from the hallway to the living room and to sit in an armchair. At 8:20 a.m., two staff were observed helping Client #3 walk down the front steps to a standard "loaner" wheelchair to ride to the van. Observation on June 22, 2012, at 9:19 a.m., revealed the client's custom molded chair had a missing left anti-tipper and left brake.

Observation of the environment on June 22, 2012, beginning at 9:36 a.m., revealed the residence was a four level split facility. The client's bedroom and the bathroom were located on the second level. Common areas (living room, dining room and kitchen were located on the first floor). Exits were observed from the client's bedroom, and from the front and back doors on the first floor, and basement, however all exit had steps. Additionally, there was no wheelchair access from the facility.

Interview with the qualified intellectual disabilities professional (QIDP, Staff #5) on June 21, 2012, at 7:19 a.m., revealed Client #3's had experienced a drastic decline in health and was expected to move to another facility soon. According to the QIDP, Client #3 received a new custom wheelchair in May 2012 to maximize his opportunities for mobility. However, further interview with the QIDP on June 22, 2012, at 10:37 a.m., revealed that the new wheelchair had become damaged and the facility was awaiting the replacement parts.

Review of a seating clinic assessment dated August 30, 2011, on June 22, 2012, at 12:03 p.m., revealed Client #3 would need to be moved to a wheelchair accessible house to

W 104 Team meetings have been held for both Client #3 and Client #2 to review their status and plan a move to an accessible location for both within the company. The BRA Southern Avenue home was chosen by the individuals and their involved legal guardians and has been approved by their IDT team. The moves will be implemented by...7-30-12.

In the interim, both will continue to receive two-person assistance for all transfer and mobility issues that require it to address their mobility needs until the move occurs. In the future BRA will ensure all adaptive equipment is in working or repaired in a timely manner if repairs are needed the appropriate adaptive equipment will be provided until the necessary repairs are completed...7-16-12

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accommodate his needs and equipment.

At the time of the survey, there was no evidence the facility timely addressed the seating clinic recommendation that Client #3 be moved to a wheelchair accessible facility.

W 130 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of three clients in the sample. (Client #2)

The finding includes:

On June 20, 2012, at 5:16 p.m., Client #2's bedroom door was observed to be wide open. The client's pants were down, exposing his underwear. Staff #2 was observed in the room beside the client. The client's roommate (Client #3) was also present in the bedroom.

Interview with Staff #2 on June 20, 2012, at 7:10 p.m., revealed he was changing Client #2's pants and waiting for the licensed practical nurse (LPN #1) to administer his medications.

There was no evidence that staff ensured Client #2's privacy during his personal care.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 104

W 130 Staff #2 will be retrained on dignity and respect considerations. In the future BRA will train staff on dignity and respect and include issues of privacy on a quarterly basis. This issue will be covered in mandatory training held in August for the entire company...06-27-12

The QIDP has informally reinforced the importance of respecting each individual's privacy and dignity as routine supports are provided. We formally trained on 06-27-12 the staff of Burns Street. In the future BRA will train on dignity and respect on a quarterly basis.....6-27-12

The QIDP and home manager will conduct routine biweekly observations of active treatment implementation to ensure that staff routinely respect privacy and dignity and will provide on-the-spot training whenever a violation is observed by the management team. In the future staff will be observed in all homes by management staff of active treatment and respecting the privacy issues of each individual in the home7-12-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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, staff interview and record verification, the qualified intellectual disabilities professional (QIDP) failed to coordinate, integrate, and monitor services, for three of three clients in the sample. (Clients #1, #2, and #3)

The findings include:

1. The QIDP (Staff #5) failed to ensure the recommendation that Client #3 be provided a gait belt was addressed timely.

On June 21, 2012, at 7:36 a.m., Client #3 was observed to require maximum assistance from a one on one staff to walk from the hallway to the living room and to sit in an armchair. At 8:20 a.m., two staff were observed helping Client #3 walk down the front steps to his wheelchair.

Interview with the QIDP (Staff #5) on June 21, 2012, at 8:00 a.m., revealed Client #3's ambulation skills had declined significantly. According to the QIDP, the physical therapist (PT) recommended the gait belt to assist the client during ambulation. Continued interview with the QIDP (Staff #5) on June 22, 2012, at 10:37 a.m., revealed the gait belt was obtained during the week prior to the survey, however, it could not be used until the staff were trained. Interview with the PT on June 22, 2012, at 4:30 p.m., revealed he was presently at the facility to train the staff on transfers and use of the gait belt.

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1. An order for an extra large gait belt is being explored by the PT as the six handle gait belt comes in one standard size but does not adjust well for the size of client #3. In the future the QIDP will ensure all adaptive equipment is obtained and is appropriate for the individual with appropriate training by the PT in a timely manner.....7-30-12

The Director has met with the QIDP to ensure that 100% reviews of adaptive equipment needs are implemented monthly with any issues discovered reported for follow up actions in the routine weekly management team meetings. In the future the QIDP will ensure that all durable medical equipment concerns are addressed in a timely manner...7-20-12

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Review of Client #3's PT assessment dated October 31, 2011, revealed, "follow-up on gait belt ". On June 22, 2012 the PT assessed the client's adaptive equipment and determined that the gait belt was too small and needed to be replaced with a wider, larger one. could not be used

At the time of the survey, there was no evidence services were coordinated to ensure the gait belt was received.

2. The QIDP (Staff #5) failed to coordinate services to address Client #3's environmental needs.

Observation of Client #3 on June 21, 2012, at 8:20 a.m., revealed he was unable to walk on level surfaces without maximum physical assistance. On June 22, 2012, at 9:17 a.m., a custom molded wheelchair was observed parked behind the front door of the first floor of the facility. The left brake and left anti-tipper of the wheelchair were noted to be missing. Continued observation on the same day, at 9:36 a.m., revealed the residence was a four level split facility and was not wheelchair accessible.

Interview with the QIDP (Staff #5) on June 21, 2012, at 7:17 a.m. revealed Client #3 had experienced a drastic decline in health and was expected to move to another facility soon. According to the QIDP, the client was prescribed a custom wheelchair in June 2011, due to the decline in his ambulation skills. Continued interview with the QIDP revealed the client received the wheelchair from the vendor in good

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2. Client #3's wheelchair has been assessed and is scheduled for repair follow up of the left anti-tipper and left brake by NRH. The necessary parts have been ordered by the vendor and repairs will be completed. In the future the QIDP will better address concerns in a timely manner ...7-30-12

Team meetings have been held for both Client #3 and Client #2 to review their status and plan a move to an accessible location for both. The BRA Southern Avenue home was chosen by the individuals, their involved family members or legal guardians and has been approved by their IDT team. The moves will be implemented by...7-30-12.

In the interim, both will continue to receive two-person assistance for transfer and mobility issues that require it to address their mobility needs...7-16-12

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condition in May 2012. Further discussion with QIDP (Staff #5) revealed that after the client received the new wheelchair, the left anti-tipper and the left brake were broken, and replacement parts were ordered. The QIDP (Staff #5) revealed that the client was using a loaner manual wheelchair until his custom wheelchair repairs could be done. Additionally, the QIDP stated that she was presently collaborating with the case manager and the interdisciplinary team to facilitate the client's relocation to a wheelchair accessible facility.

Review of a seating clinic assessment dated August 30, 2011, on June 22, 2012, at 12:03 p.m., revealed Client #3 would need to be moved to a wheelchair accessible house to accommodate his needs and equipment.

At the time of the survey, however, there was no evidence the facility's QIDP had coordinated services timely to address Client #3's specific environmental and ambulation needs.

3. The QIDP failed to coordinate services to ensure Client #2's legs were elevated to prevent swelling.

Observation on June 20, 2012, at approximately 5:29 p.m., revealed Staff #2 assisted Client #2 from his bedroom to the dining room by holding his arms. As the client took each step, he was observed slowly dragging his legs. The client then sat in the dining room and listened to music. At 6:14 p.m., the client remained at the table for dinner.

On June 20, 2012, at 7:12 p.m., review of an

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3. The staff members have been trained on elevating the feet of Client #2 and all other elements of the HMCP for each person supported in the home. In the future the QIDP will ensure that all staff are properly trained and aware of all elements of the HMCP for each individual in the home...7-3-12

BRA will ensure that staff new to working with client #2 are properly trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-30-12

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unusual incident report dated February 3, 2012, revealed the licensed practical nurse was unable to get a pulse from Client #2's left leg. As a result, the client was taken to the emergency room. At 7:14 p.m., review of the discharge report dated February 3, 2012, revealed Client #2 was diagnosed with bilateral leg swelling. Further review revealed an order for Furosemide 20 mg every morning and to elevate the client's legs.

Further observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Client #2, was seated at the dining room table participating in table top activities. At approximately 11:30 a.m., Staff #1 walked Client #2 around the house. As the client took each step, he was observed slowly dragging his legs. At approximately 12:00 p.m., Client #2 sat at the dining room table for lunch. After lunch, the client remained seated at the dining room table and continued to participate in table top activities with Staff #1. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the client's lower legs were swollen.

On June 22, 2012, at 10:13 a.m., review of the medical records revealed a primary care physician note dated February 8, 2012, that instructed to elevate Client #2's legs when sitting. On the same day, at 2:24 p.m., review of the client's PT assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes." However, during the survey period, the facility failed to ensure that the client's legs were elevated.

W 159 BRA will also ensure that senior staff provide mentoring to staff new to the individuals in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment protocols...7-30-12

The QIDP and home manager will monitor compliance at minimum twice monthly (separately) to ensure ongoing compliance with the monitoring of active treatment implementation...7-30-12

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Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the client for two weeks and had not been trained to elevate the client's legs when sitting. Interview with LPN #2 also revealed the client should have his legs elevated when sitting to prevent his legs from swelling.

There was no evidence that the QIDP (Staff #5) coordinated with nursing services to ensure staff training and implementation of Client #1's recommendation for leg elevation.

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W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure staff was provided with initial and continuing training that enable them to perform their duties effectively, efficiently, and competently, for two of three residents in the sample. (Residents #1 and #2)

The finding includes:

1. The facility failed to ensure each staff was trained to elevate Resident #2's legs to prevent swelling.

Observation on June 20, 2012, at approximately 5:29 p.m., revealed Staff #2 assisted Resident #2 from his bedroom to the dining room by holding his arms. As the resident took each step, he was

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observed slowly dragging his legs. The resident then sat in the dining room and listened to music. At 6:14 p.m., the resident remained at the table for dinner.

On June 20, 2012, at 7:12 p.m., review of an unusual incident report dated February 3, 2012, revealed the licensed practical nurse was unable to get a pulse from Resident #2's left leg. As a result, the resident was taken to the emergency room. At 7:14 p.m., review of the discharge report dated February 3, 2012, revealed Resident #2 was diagnosed with bilateral leg swelling. Further review revealed an order for Furosemide 20 mg every morning and to elevate the resident's legs.

Further observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Resident #2, was seated at the dining room table participating in table top activities. At approximately 11:30 a.m., Staff #1 walked Resident #2 around the house. Staff #1 held the resident by his arms as he took each step with a slow drag. At approximately 12:00 p.m., Resident #2 sat at the dining room table for lunch. After lunch, the resident remained seated at the dining room table and continued to participate in table top activities with Staff #1. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the resident's lower legs were swollen.

On June 22, 2012, at 10:13 a.m., review of the medical records revealed a primary care physician note dated February 8, 2012, that instructed to elevate Resident #2's legs when sitting. On the same day, at 2:24 p.m., review of

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1. The staff members have been trained on elevating the feet of Client #2 and all other elements of the HMCP for each person supported. In the future the QIDP will ensure that training is done on HMCP and elements of the treatment plan outlined on a quarterly basis...7-03-12

BRA will ensure that new staff hired and any new staff working with the individuals is trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-30-12

BRA will also ensure that senior staff provide mentoring to new staff in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment protocols...7-30-12

The QIDP and home manager will monitor compliance at minimum twice monthly (separately) to ensure ongoing compliance...7-30-12

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the resident's physical therapy assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes." However, during the survey period, the facility failed to ensure that the resident's legs were elevated.

Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the resident for two weeks and had not been trained to elevate the resident's legs when sitting. Interview with LPN #2 also revealed the resident should have his legs elevated when sitting to prevent his legs from swelling.

Review of the facility's training book on June 22, 2012, at 3:30 p.m., failed to provide evidence that the staff was trained to elevate Resident #2's legs as ordered.

2. The facility failed to ensure that staff were trained to implement Resident #1's active treatment program designed to reduce his eating pace, as evidence below:

On June 20, 2012, beginning at 6:11 p.m., Resident #1 was observed eating chopped fish, turnip greens, navy beans and pears at a fast pace. Direct support staff #3 asked the resident to slow down, but the resident continued to eat fast. At 6:15 p.m., Resident #1 drank his water and cranberry juice fast. Staff #3 asked him to slow down; but the resident continued to drink rapidly.

Review of Resident #1's individual program plan (IPP) dated December 2, 2011 on June 21, 2012,

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2. The QIDP retrained the staff on the program 2.B for slowing his eating pace for Client #1 aimed at reducing his eating pace. In the future the QIDP will ensure staff are re-trained on active treatment programs at least quarterly... 7-05-12

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at 9:00 a.m., revealed an objective that stated, "Will slow his eating pace during breakfast lunch and dinner 100% of the time with verbal prompts for six months." Further review of the IPP revealed the following steps:

- a. The resident will pick up his fork or spoon;
- b. The resident will scoop fork or spoon into food;
- c. The resident will bring his fork or spoon to his mouth;
- d. The resident will take his food off the fork or spoon with his mouth;
- e. Resident will put fork or spoon on the plate after each mouth full;

During the mealtime observation, Staff #3 failed to prompt the resident to put his spoon on the plate to slow his eating pace.

Interview with the qualified intellectual disabilities professional (QIDP) on June 22, 2012, at approximately 3:00 p.m., revealed Staff #3 was required to prompt Resident #1 to put his spoon on his plate after each mouth full of food.

At the time of the survey, the facility failed to ensure that each staff was trained to implement the Resident #1's IPP as recommended.

W 227 483.440(c)(4) INDIVIDUAL PROGRAM PLAN

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

W 189

A new procedure will be implemented requiring staff to read the mealtime protocol prior to beginning the meal and providing the mealtime support so that the protocol mandates are fresh in the support staff's mind. This will be done by providing each shift with a daily activity schedule that outlines what should be done on each shift for each individual... 7-30-12

The QIDP and Home Manager will observe at minimum three meals weekly (separately) to ensure that proper supports are routinely provided. In the future the QIDP will ensure that mealtime observations occur weekly and train any staff as needed. On-the-spot training and/or appropriate disciplinary action will be taken as required... 7-30-12

W 227

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W 227 Continued From page 11

W 227 W227

This STANDARD is not met as evidenced by:
Based on observations, interviews and the review of records, the facility failed to ensure that each client's individual program plan stated specific objectives necessary to meet each client's needs, as identified by the comprehensive assessment, for one of three clients in the sample. (Client #2)

The finding includes:

On June 20, 2012, beginning at 6:14 p.m., direct support staff (Staff #1) was observed feeding Client #2 with a built up handle spoon. Continued observation revealed the staff spoon fed the client his entire meal without hand over hand assistance.

Review of Client #2's occupational therapy (OT) assessment dated May 12, 2012, on June 22, 2012, at 2:30 p.m., revealed an objective that stated, "Given verbal cues (2), [the client] will use his built-up handle spoon for mealtime 50% of the time for 12 consecutive months."

Interview with the qualified intellectual disabilities professional (QIDP, Staff #5) on June 22, 2012, at approximately 4:45 p.m., revealed the occupational therapist did not forward the assessment to the facility timely. Further discussion with the QIDP revealed that as a result, the recommendation to implement the objective had not been reviewed and approved by the interdisciplinary team.

The measurable objective to provide Client #2 with the opportunity to feed himself given the appropriate level of staff assistance will be trained with staff and the OT will be requested to come in as re- assess Client #2 for the feeding program7-19-12

In the future, the QIDP will ensure that follow up is done to obtain needed clinical assessment recommendations in a timely manner and if not, to follow up after the fact to ensure that any recommendations that are important to the person's health, welfare or skills development are added via the addendum process...7-20-12

The QIDP will audit the individual records monthly to ensure that all recommendations are addressed in a timely manner and the audit findings will be reviewed with the management team during weekly management team meetings. In the future a meeting will be held with all consultants to ensure they understand the importance of having all assessments turned in a timely manner.....7-30-12

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W 227	Continued From page 12 The QIDP confirmed that she did not include the objective in the clients IPP.	W 227		
W 331	483.460(c) NURSING SERVICES	W 331		

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of three or three clients in the sample. (Clients #1, #2, and #3)

The findings include:

1. The facility's nursing services failed to ensure treatments prescribed to be done before the administration of medication were performed consistently and documented.

On June 21, 2012, beginning at 5:01 p.m., the licensed practical nurse (LPN #1) was observed to administer medications to the clients. Interview with LPN #1, during this time, revealed that the clients also received medications in the morning for blood pressure and diabetes.

Review of the medication administration record (MAR) on June 21, 2012, at 5:32 p.m., revealed circles around the nurse's initials for prescribed treatments, on several days during June 2012. The circles revealed that Clients #1, #2, and #3 had not received monitoring of blood pressures and fingersticks.

Interview with the primary licensed practical nurse

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W 331 Continued From page 13
(LPN #2) on June 22, 2012, at approximately 1:00 p.m., revealed that LPN #3 documented in the record that the aforementioned prescribed treatments were not done. According to LPN #2, LPN #3 should have immediately notified her; however, she learned that the treatments had not been administered "after the fact."

Further review of the clients' prescribed treatment orders on June 22, 2012, beginning at 1:12 p.m., revealed the following:

a. Client #1 had an order for, "Metformin 500 mg, take one tablet once daily with breakfast for diabetes and to have a daily fingerstick before breakfast." Review of the "Glucose Monitoring Daily Form (in the morning before breakfast)", for June 2012, revealed no entries for June 1 and 4, 2012; "No equipment" for June 2, or 3, 2012; and "unable to perform" on June 17, 2012.

b. Client #1 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.). The client was prescribed HCTZ 25 mg each morning and Amlodipine 10 mg tab each morning for hypertension (6:00 a.m.). Review of the MAR revealed the client was administered these medications on June 2, 2012, at 6:00 a.m., however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's blood pressure was verified as prescribed prior to administering his anti-hypertension medications.

c. Client #2 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic

W 331

On 7/5/12, the RN held a meeting with nursing staff including those identified in the survey. Nursing is clear that blood pressures and blood sugars MUST be taken prior to administration of medications when ordered. When a piece of equipment is missing or not working, the nurse MUST call either nurse 1 or 2 immediately for guidance, replacement, or an MD order to allow administration without measurement. This was effective immediately. 7/5/12

As of 8/1/12, all nursing staff will use THERAP to document notes on all individuals so that they can be reviewed 24/7 by the RN and any concerns missed can be picked up. This does not take the place of calling nurse 1 or 2 for broken or missing equipment or other concerns that a reasonably prudent nurse would act on in notifying the supervising nurse. RN is working with nurses on using the computer system. 7-30-12 BRA will ensure that new staff to the home is trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-05-12

BRA will also ensure that senior staff provide mentoring to all new staff in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment and protocols...7-05-12

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W 331 Continued From page 14

greater than 150 and diastolic greater than one hundred (6:00 a.m.). The client was prescribed HCTZ 25 mg once daily for hypertension (6:00 a.m.). Review of the MAR revealed the client was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's blood pressure was verified as prescribed prior to administering his anti-hypertension medication.

d. Client #3 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.). The client was prescribed Lorsartan/HCTZ 100 mg/25 mg, take 1 tablet daily for blood pressure (6:00 a.m.) Review of the MAR revealed the client was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's blood pressure was verified as prescribed, prior to administering his anti-hypertension medication.

At the time of the survey, there was no evidence that facility's nursing services ensured that all prescribed treatments were performed.

2. The facility's nursing services failed to ensure that Client #2's legs were elevated as recommended to prevent bilateral swelling, as evidenced below:

Observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Client #2, was seated at the dining room table participating in table top activities until approximately 11:30

W 331

Additionally, the Daily Activity Schedules of each person supported will be refined; the one-page document reflecting 24/7 activities and supports will be replaced by schedules for each shift (overnight, day and evening); this will allow the QIDP to provide more detailed guidance for each shift. Staff will be trained on the revised schedules and instructed to review and follow them in completing their primary duties for the shift.....7-30-12

The RN will ensure that the HMCP outlines for staff and nursing all follow up steps for the diabetes and blood pressure issues. In the future this information will be outlined on the daily activity sheet and staff will be trained on all the additional information that has been added.....7-30-12

The RN will ensure that the HMCP reflects strategies to address all active problems each individual has and that staff is trained on 100% of the follow up steps outlined...7-30-12

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W 331 Continued From page 15
a.m., without his legs elevated. At approximately 12:00 p.m., Client #2 sat at the dining room table for lunch and remained sitting to participate in table top activities, without his legs elevated. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the client's lower legs were swollen.

On June 22, 2012, at 10:13 a.m., review of a primary care physician note dated February 8, 2012, revealed it prescribed to elevate Client #2's legs when sitting. At 2:24 p.m., review of the client's physical therapy assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes."

Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the client for two weeks and had not been trained to elevate the client's legs when sitting. Interview with LPN #2 on the same day at 4:38 p.m., revealed the client would benefit from having his legs elevated when sitting to minimize swelling.

At the time of the survey, however, there was no evidence nursing services implemented measures to ensure Client #2's legs were elevated as prescribed to prevent swelling.

W 331

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

W 368

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W 368 Continued From page 16

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that medications were administered in compliance with physicians' orders for three of three clients in the sample. (Clients #1, #2, and #3).

The findings include:

The facility's nursing services failed to ensure treatments prescribed to be done before the administration of medication were performed consistently and documented.

On June 21, 2012, beginning at 5:01 p.m., the licensed practical nurse (LPN #1) was observed to administer medications to the clients. Interview with LPN #1, during this time, revealed that the clients also received medications in the morning for blood pressure and diabetes.

Review of the medication administration record (MAR) on June 21, 2012, at 5:32 p.m., revealed circles around the nurse's initials for prescribed treatments, on several days during June 2012. The circles revealed that Clients #1, #2, and #3 had not received monitoring of blood pressures and fingersticks.

Interview with the primary licensed practical nurse (LPN #2) on June 22, 2012, at approximately 1:00 p.m., revealed that LPN #3 documented in the record that the aforementioned prescribed treatments were not done. According to LPN #2, LPN #3 should have immediately notified her; however, she learned that the treatments had not been administered "after the fact."

W 368

W368

On 7/5/12, the RN held a meeting with nursing staff including those identified in the survey. Nursing is clear that blood pressures and blood sugars MUST be taken prior to administration of medications when ordered. When a piece of equipment is missing or not working, the nurse MUST call either nurse 1 or 2 immediately for guidance, replacement, or an MD order to allow administration without measurement. This was effective immediately..... 7-05-12

As of 8/1/12, all nursing staff will use THERAP to document notes on all individuals so that they can be reviewed 24/7 by the RN and any concerns missed can be picked up. This does not take the place of calling nurse 1 or 2 for broken or missing equipment or other concerns that a reasonably prudent nurse would act on in notifying the supervising nurse. RN is working with nurses on using the computer system... 8-01-12

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W 368 Continued From page 17

W 368

Further review of the clients' prescribed treatment orders on June 22, 2012, beginning at 1:12 p.m., revealed the following:

a. Client #1 had an order for, "Metformin 500 mg , take one tablet once daily with breakfast for diabetes and to have a daily fingerstick before breakfast." Review of the "Glucose Monitoring Daily Form (in the morning before breakfast)", for June 2012, revealed no entries for June 1 and 4, 2012; "No equipment" for June 2, or 3, 2012; and "unable to perform" on June 17, 2012.

b. Client #1 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.)." The client was prescribed HCTZ 25 mg each morning and Amlodipine 10 mg tab each morning for hypertension (6:00 a.m.). Review of the MAR revealed the client was administered these medications on June 2, 2012, at 6:00 a.m., however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's blood pressure was verified as prescribed prior to administering his anti-hypertension medications.

c. Client #2 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.)." The client was prescribed HCTZ 25 mg once daily for hypertension (6:00 a.m.). Review of the MAR revealed the client was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's

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W 368 Continued From page 18
blood pressure was verified as prescribed prior to administering his anti-hypertension medication.

W 368

d. Client #3 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.). The client was prescribed Lorsartan/HCTZ 100 mg/25 mg, take 1 tablet daily for blood pressure (6:00 a.m.) Review of the MAR revealed the client was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the client's blood pressure was verified as prescribed, prior to administering his anti-hypertension medication.

W 381 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING

W 381

The facility must store drugs under proper conditions of security.

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to store drugs under proper conditions of security, for five of the six clients residing in the facility. (Clients #1, #2, #3, #5 and #6)

The finding includes:

On June 22, 2012, at 5:05 p.m., licensed practical nurse #1 (LPN) was observed administering Client #4's medication in the living room while Client #1, #2, #3, #5 and #6 medications were left on the kitchen counter. Other clients and staff were in close proximity to the medication.

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W 381 Continued From page 19
Interview with the LPN #1 on June 23, 2012, at approximately 5:00 p.m., confirmed the medications were left unsecured.

Interview with the licensed practical nurse (LPN #2) coordinator on June 23, 2012, at approximately 3:30 p.m., revealed that all medications were required to be secured at all times by a licensed professional.

The LPN failed to ensure the security of all drugs during the evening medication administration on June 20, 2012.

W 381 W381
RN discussion with nursing staff regarding not leaving medications unattended due to safety concerns. All nursing staff understand that medications are not to be left unattended or out of direct sight for safety of the individuals..... 7-05-12

The RN, QIDP and Home Manager will observe medication administration at minimum once weekly (separately) to ensure consistent compliance of the passing of medication. If the QIDP or Home Manager observes issues, they will immediately report to the RN for follow up and action to be taken.....7-30-12

W 436 483.470(g)(2) SPACE AND EQUIPMENT

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.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices were furnished and maintained in good repair for two of three clients in the sample. (Clients #2 and #3)

W 436 W436

The findings include:

1/2. The permanent wheelchair of Client #3 is scheduled to be repaired by...7-19-12
The PT is scheduled to train staff and Client #3 on the appropriate use of the chair on the same date...7-19-12

The findings include:

1. The facility failed to ensure Client #3's loaner manual wheelchair adequately addressed his mobility needs.

On June 21, 2012, at 8:20 a.m., two staff were

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W 436 Continued From page 20

observed helping Client #3 down the front steps to a standard wheelchair to ride to the van. The client was very tall and the wheelchair did not appear to comfortably accommodate his long legs.

Interview with the qualified intellectual disabilities professional (QIDP), Staff #5, on June 22, 2012, at 8:00 a.m., revealed Client #3 was using the standard loaner wheelchair for mobility until his custom molded wheelchair could be repaired. Direct interview with the physical therapist, at approximately 5:30 p.m., revealed he was at the facility to provide training and would evaluate Client #3's loaner wheelchair. The PT confirmed that the seat of the loaner chair did not accommodate the client's leg length. Therefore, the PT, recommended that the facility contact the vendor to obtain an appropriate size wheelchair for the client until his custom wheelchair is modified.

The facility failed to ensure Client #3's had an appropriately sized wheelchair.

2. The facility failed to ensure Client #3's custom molded wheelchair was maintained in good repair.

Observation on June 22, 2012 at 9:17 a.m., revealed a custom molded wheelchair parked behind the front door on the first floor of the facility. The left brake and the left anti-tipper were noted to be missing from the wheelchair.

Interview with the house manager, Staff #4, on June 22, 2012, at 9:19 a.m., revealed that the chair observed behind the door was Client #3's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE WASHINGTON, DC 20019
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W 436 Continued From page 21

new custom wheelchair, which he received in May 2012. Interview with the QIDP (Staff #5) on the same day at 10:37 a.m. revealed the left brake and left anti-tipper, were broken after the client received the wheelchair, requiring the wheelchair technician to remove them to obtain the appropriate replacement parts.

Interview with the PT on June 22, 2012, at 5:07 p.m., revealed that he was in the facility to train the staff on and wheelchair management. The PT stated that while at the facility, he would evaluate Client #3's custom molded wheelchair to determined its continued appropriateness for the client.

At the time of the survey, the facility failed to ensure that the brake and anti-tipper on Client #3's custom wheelchair were maintained in good repair to facilitate its continued use by the client.

3. The facility failed to ensure that Client #2's wheelchair was maintained in good repair.

Observation of Client #2 on June 21, 2012, at 8:09 a.m., revealed he required verbal prompts and the maximum assistance of two staff for approximately two minutes to walk down the front steps of the facility. He was then assisted by two staff to walk along the paved area to the street, where he sat in his wheelchair, and was escorted to the van by staff in his manual wheelchair. Further observation of the wheelchair on June 22, 2012 at 9:15 a.m., revealed one of the spokes (braces connecting the hub and rim of a wheel) in the left rear wheel was broken.

Interview with the QIDP (Staff #5) on June 21,

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W 436	<p>Continued From page 22</p> <p>2012, at 8:00 a.m., revealed Client #2's ambulation skills had declined significantly and that he now required a wheelchair for distance travel. Interview with the home manager on June 22, 2012, at 9:15 a.m., and with the QIDP (Staff #5) on the same day at 10:07 respectively revealed they were not aware of the damage to the rear wheel of the client ' s wheelchair.</p> <p>At the time of the survey, the facility failed to ensure Client #2's wheelchair was maintained in good repair.</p> <p>4. The facility failed to ensure that Client #3 received a recommended gait belt.</p> <p>On June 21, 2012, at 7:36 a.m., Client #3 was observed to require maximum assistance from his one on one to walk from the hallway into the living room and to sit in an armchair. On June 22, 2012 at approximately 10:22 a.m., the QIDP (Staff #5) showed the surveyor a new gait belt and stated that it belonged to Client #3.</p> <p>Interview with the QIDP (Staff #5) on June 21, 2012, at 8:00 a.m., revealed Client #3's ambulation skills had declined significantly. According to the QIDP (Staff #5), the gait belt was obtained during the week before the survey to assist the client during ambulation. The QIDP (Staff #5) revealed that the use of the gait belt would be initiated as soon as staff were trained on how to use it. Interview with the PT on June 22, 2012 at p.m., at 4:30 p.m. revealed he was present to train the staff on on transfers, use of the gait belt and wheelchair management.</p> <p>Record review on June 22, 2012, at 11:50 a.m.</p>	W 436	<p>3 Client #2's distance travel wheelchair will be repaired by...7-30-12</p> <p>4 An extra large, appropriately sized, gait belt has been requested by the PT and will be ordered for Client #3 and will be obtained by...7-30-12</p> <p>The administrator met with the QIDP to ensure that the routine monthly audit of all needed adaptive equipment is implemented on a consistent monthly basis and reported during weekly team meetings (first Monday meeting of each month). Issues discovered must be addressed via timely action steps...8-1-12 The QIDP will report the status of all outstanding action steps in each weekly team meeting until all outstanding issues are resolved...beginning 8-1-12</p>	

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W 436 Continued From page 23
revealed a PT assessment dated October 31, 2011 which stated "follow-up on gait belt ". However, the PT assessment dated June 22, 2012 revealed that the current (new) gait belt needed be returned because it did not accommodate the client's girth. At the time of the survey, the facility failed to ensure that Client #3 was timely provided a gait belt for use during ambulation as recommended.

5. Observation on June 20, 2012, at approximately 5:29 p.m., revealed Staff #2 assisted Client #2 from his bedroom to the dining room by holding his arms. As the client took each step, he was observed slowly dragging his legs. The client then sat in the dining room and listened to music. At 6:14 p.m., the client remained at the table for dinner.

On June 20, 2012, at 7:12 p.m., review of an unusual incident report dated February 3, 2012, revealed the licensed practical nurse was unable to get a pulse from Client #2's left leg. As a result, the client was taken to the emergency room. At 7:14 p.m., review of the discharge report dated February 3, 2012, revealed Client #2 was diagnosed with bilateral leg swelling. Further review revealed an order for Furosemide 20 mg every morning and to elevate the client's legs.

Further observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Client #2, was seated at the dining room table participating in table top activities. At approximately 11:30 a.m., Staff #1 walked Client #2 around the house. Staff #1 held the client by his arms as he took each step with a slow drag. At approximately 12:00 p.m., Client #2 sat at the dining room table

W 436

5 New TED stockings have been ordered for Client #2 and will be obtained by...7-19-12
The HMCP will reflect the mandate for staff to report immediately to the RN if TED stockings are found to be in disrepair so that replacements can be obtained in a timely manner. Staff will be trained on this mandate by...7-23-12

The new staff members have been trained on elevating the feet of Client #1 and all other elements of the HMCP for each person supported...7-1-12

BRA will ensure that new staff is trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-30-12

BRA will also ensure that senior staff provide mentoring to new staff in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment protocols...7-30-12

The QIDP and home manager will monitor compliance at minimum twice monthly (separately) to ensure ongoing compliance...7-30-12

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W 436 Continued From page 24

for lunch. After lunch, the client remained seated at the dining room table and continued to participate in table top activities with Staff #1. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the client's lower legs were swollen.

On June 22, 2012, at 10:13 a.m., review of the medical records revealed a primary care physician note dated February 8, 2012, that instructed to elevate Client #2's legs when sitting. On the same day, at 2:24 p.m., review of the client's physical therapy assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes." However, during the survey period, the facility failed to ensure that the client's legs were elevated.

Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the client for two weeks and had not been trained to elevate the client's legs when sitting. Interview with LPN #2 also revealed the client should have his legs elevated when sitting to prevent his legs from swelling and that the client should wear ted stockings. Continued interview indicated that Client #2 support stockings had torn and there were no more support stockings available.

On June 22, 2012, at 12:35 p.m., review of the medical records revealed a vascular specialty report dated April 27, 2012 that stated Client #2 has edema in his lower legs and should wear support stockings.

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W 436 Continued From page 25
At the time of the survey, there was no evidence the facility ensure that the client was proved ted stockings to manage his bilateral leg edema as recommended.

W 436

W 440 483.470(i)(1) EVACUATION DRILLS

W 440

The facility must hold evacuation drills at least quarterly for each shift of personnel.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to have records to verify a record of evacuation drills conducted quarterly on all shifts, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)

The finding includes:

The facility failed to provide evidence that simulated fire drills were conducted at least four times (4) a year for each shift, as follows:

On June 22, 2012 at 3:47 p.m., interview with the facility's qualified intellectual disabilities professional (Staff #5) revealed that there were three designated shifts (8:00 a.m. - 4:30 p.m.; 4:00 p.m. - 12:00 a.m.; and, 12:00 p.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two weekend designated shifts (8:00 a.m. - 8:30 p.m. and 8:00 p.m. - 8:30 a.m.) on Saturdays and Sundays. Continued discussion with (Staff #5) revealed that fire drills are conducted at least quarterly for each shift of duty.

Review of the presented fire drill records On June 22, 2012, at 3:53 p.m., revealed none were

W440

The cited fire drill documentation was inadvertently purged from the records but has been recovered by the QIDP placed in the fire book and was available for the fire inspection. In the future when purging the fire book all fire drills will remain for one year in the book and once purged will be placed in an assigned book in order to locate them whenever needed...6-24-12

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W 440 Continued From page 26
available for the period of June 2011 through
December 2011.

W 440

Further discussion with the qualified intellectual disabilities professional (Staff #5) on June 22, 2012 at 4:55 p.m. indicated that fire drills were held during June 2011 through December 2011 for all shifts and that the records would be provided for review; however no further drill records were provided.

BRA will ensure that fire drill documentation is scanned and maintained in an electronic file as well as a hard copy file in the book... 7-01-12

At the time of the survey, there was no evidence that fire drills were conducted quarterly on each shift, as required.

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1 000 INITIAL COMMENTS 1 000

A relicensure survey was conducted from June 20, 2012, through June 22, 2012. A sampling of three residents was selected from a population of six residents with varying degrees of intellectual disabilities.

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

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

1 090 3504.1 HOUSEKEEPING 1 090

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was maintained in a safe and orderly manner for six of six residents in the facility. (Residents #1, #2, #3, #4, #5, and #6)

The findings include:

On June 22, 2012, beginning at 9:36 a.m., the house manager (Staff #4) and the qualified intellectual disabilities professional (Staff #5) accompanied the surveyor through the facility to

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESANTATIVE'S SIGNATURE *Linda Salzman* TITLE *Program Director* (X6) DATE *07/17/2012*

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1090	<p>Continued From page 1</p> <p>conduct the environmental observations.</p> <p>The following concerns were identified:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure closet doors were maintained in good repair. <ol style="list-style-type: none"> a. A folding door was leaning against the wall beside the closet in the bedroom of Residents #2 and #3. Interview with Staff #4 confirmed that the door belonged on the tract at the closet entrance. b. The sliding door of the linen closet was loose at the bottom, causing it to move back and forth when pressure was applied. The closet was located to the right of the hallway, leading to the bathroom on the upper level of the facility. c. The closet door in Resident #1's bedroom was not secured in the tract. It was later noted to be completely detached from the tracts. 2. There was dried dark substance on the bottom of the cabinet underneath the kitchen sink. 3. The barrel grill located in the backyard had holes in bottom. Interview with the qualified intellectual disabilities professional (Staff #5) revealed that the newer grill beside it was the one being used. She further stated that she would request that the old one to be removed from the premises. 4. There was a heavy accumulation of hard powdered substance in and around the detergent dispenser located on the door of the dishwasher. Dishes and cups inside the dishwasher were noted to feel very hot when touched. At 10:49 a.m., a portion of a plastic fork was retrieved from the bottom of the dishwasher. 	1090		
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			<ol style="list-style-type: none"> 1a. The closet doors have been put in place in the bedroom for Client #2 and Client #3.....7-10-12 1b. The sliding door on the linen closet is being repaired and tracks have been placed for the doors so that they are not loosed.....7-19-12 1c. The closet door on Client #1 bedroom has been secured on the tract.....7-10-12 2. The dried dark substance underneath the kitchen cabinet and has been thoroughly cleaned and removed from the bottom of the cabinet.....6-26-12 3. The barrel grill located in the backyard of the home with holes in the bottom was removed and a new grill was purchased on.....6-28-12 4. The dishwasher was removed and a new dishwasher was purchased for the home on 6-26-12. In the future staff have been instructed to clean out any debris in the dishwasher on a daily basis. No plastic will be placed in the dishwasher and only the required amount of dishwasher fluid is to be used. The bottom of the dishwasher must be checked after every use....7-08-12 	
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I 090 Continued From page 2

I 090

Interview with the home manager (Staff #4) at this time revealed the observed substance was dishwasher detergent, which had accumulated because the dishwasher was not operating properly. Further discussion with Staff #4 revealed that she washed the dishes in soapy water, rinsed them twice, then placed them in the dishwasher to go through the dishwashing cycle. At 10:47 a.m., the qualified intellectual disabilities professional (Staff #5) and the program coordinator (Staff #6) were informed of the problem. The program coordinator stated she had not been informed that the dishwasher was not working properly, and would request the maintenance personnel to assess the problem. At the time of the survey exit, the dishwasher remained inoperable.

I 109 3504.16 HOUSEKEEPING

I 109

Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP).

This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that clothing items were labeled inconspicuously, for five of the six residents residing in the facility. (Residents #1, #2, #4, #5 and #6)

The finding includes:

On June 20, 2012, at 5:52 p.m., Residents #2, #4 and #5 were observed with their initials written

3504.16

The Acting House Manager will audit the clothing of each individual person supported to identify all clothing that has been improperly labeled by staff. All that can be altered and salvaged will be addressed and retrain staff on proper labeling techniques to follow. All that cannot be salvaged will be discarded and replaced by the company and not the individuals personal funds.....7-01-12

Staff will be trained in properly marking clothing in an inconspicuous manner. The Acting House Manager will supervise the identification of personal items to ensure the process is done properly on a routine basis.....7-01-12

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I 109 Continued From page 3 I 109

across the top of their shirts in large black letters. At 6:06 p.m., Resident #6 was observed wearing white socks with his initials written in large black letters. On June 21, 2012, at 8:22 a.m., Client #1's shirt was observed to have his initial's written in black letters near the neck of his shirt.

Interview with the qualified intellectual disabilities professional (QIDP, Staff #5) and the house manager (HM) on June 22, 2012, at approximately 4:30 p.m., confirmed the residents' labels were not inconspicuous.

I 135 3505.5 FIRE SAFETY I 135

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 staff interview and the review of fire drill reports, the group home for persons with intellectual disabilities (GHPID) failed to provide evidence of evacuation drills at least quarterly for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6)

The finding includes:

The facility failed to provide evidence that simulated fire drills were conducted at least four times (4) a year for each shift, as follows:

On June 22, 2012 at 3:47 p.m., interview with the facility's qualified intellectual disabilities professional (Staff #5) revealed that there were three designated shifts (8:00 a.m. - 4:30 p.m.; 4:00 p.m. - 12:00 a.m.; and, 12:00 p.m. - 8:00 a.m.), Monday through Friday. Further interview

3505.5

The cited fire drill documentation was inadvertently purged from the records but has been recovered by the QIDP placed in the fire book and was available for the fire inspection for all five shifts in thehome including the two weekend shifts. In the future when purging the fire book all fire drills will remain for one year in the book and once purged will be placed in an assigned book in order to locate them whenever needed...6-24-12

BRA will ensure that fire drill documentation is scanned and maintained in an electronic file as well as a hard copy file in the fire book...7-01-12

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I 135	Continued From page 4	I 135		
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revealed that there were two weekend designated shifts (8:00 a.m. - 8:30 p.m. and 8:00 p.m. - 8:30 a.m.) on Saturdays and Sundays. Continued discussion with Staff #5 revealed that fire drills are conducted at least quarterly for each shift of duty.

Review of the presented fire drill records on June 22, 2012, at 3:53 p.m., revealed none were available for the period of June 2011 through December 2011.

Further discussion with the qualified intellectual disabilities professional (Staff #5) on June 22, 2012 at 4:55 p.m. indicated that fire drills were held during June 2011 through December 2011 for all shifts and that the records would be provided for review; however no further drill records were provided.

At the time of the survey, there was no evidence that fire drills were conducted quarterly on each shift, as required.

I 180	3508.1 ADMINISTRATIVE SUPPORT	I 180		
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Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

This Statute is not met as evidenced by:
Based on observation, staff interview and record verification, the qualified intellectual disabilities professional (QIDP, Staff #5) failed to coordinate, integrate, and monitor services, for three of three residents in the sample. (Residents #1, #2, and #3)

The findings include:

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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE WASHINGTON, DC 20019
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I 180 Continued From page 5

I 180

1. The QIDP (Staff #5) failed to ensure the recommendation that Resident #3 be provided a gait belt was addressed timely.

On June 21, 2012, at 7:36 a.m., Resident #3 was observed to require maximum assistance from a one on one staff to walk from the hallway to the living room and to sit in an armchair. At 8:20 a.m., two staff were observed helping Resident #3 walk down the front steps to his wheelchair.

Interview with the QIDP (Staff #5) on June 21, 2012, at 8:00 a.m., revealed Resident #3's ambulation skills had declined significantly. According to the QIDP, the physical therapist (PT) recommended the gait belt to assist the resident during ambulation. Continued interview with the QIDP (Staff #5) on June 22, 2012, at 10:37 a.m., revealed the gait belt was obtained during the week prior to the survey, however, it could not be used until the staff were trained. Interview with the PT on June 22, 2012, at 4:30 p.m., revealed he was presently at the facility to train the staff on transfers and use of the gait belt.

Review of Resident #3's PT assessment dated October 31, 2011, revealed, " follow-up on gait belt ". On June 22, 2012 the PT assessed the resident's adaptive equipment and determined that the gait belt was too small and needed to be replaced with a wider, larger one.

At the time of the survey, there was no evidence services were coordinated to ensure the gait belt was received.

2. The QIDP (Staff #5) failed to coordinate services to address Resident #3's environmental needs.

3508.1

1. An order for an extra large gait belt is being explored by the PT as the six handle gait belt comes in one standard size but does not adjust well for the size of client #3. In the future the QIDP will ensure all adaptive equipment is obtained and is appropriate for the individual with appropriate training by the PT in a timely manner.....7-30-12

The Director has met with the QIDP to ensure that 100% reviews of adaptive equipment needs are implemented monthly with any issues discovered reported for follow up actions in the routine weekly management team meetings. In the future the QIDP will ensure that all durable medical equipment concerns are addressed in a timely manner...7-20-12

2. Client #3's wheelchair has been assessed and is scheduled for repair follow up of the left anti-tipper and left brake by NRH. The necessary parts have been ordered by the vendor and repairs will be completed. In the future the QIDP will better address concerns in a timely manner ...7-30-12

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I 180

Observation of Resident #3 on June 21, 2012, at 8:20 a.m., revealed he was unable to walk on level surfaces without maximum physical assistance. On June 22, 2012, at 9:17 a.m., a custom molded wheelchair was observed parked behind the front door of the first floor of the facility. The left brake and left anti-tipper of the wheelchair were noted to be missing. Continued observation on the same day, at 9:36 a.m., revealed the residence was a four level split facility and was not wheelchair accessible.

Interview with the QIDP (Staff #5) on June 21, 2012, at 7:17 a.m. revealed Resident #3 had experienced a drastic decline in health and was expected to move to another facility soon. According to the QIDP, the resident was prescribed a custom wheelchair in June 2011, due to the decline in his ambulation skills. Continued interview with the QIDP revealed the resident received the wheelchair from the vendor in good condition in May 2012. Further discussion with QIDP (Staff #5) revealed that after the resident received the new wheelchair, the left anti-tipper and the left brake were broken, and replacement parts were ordered. The QIDP (Staff #5) revealed that the resident was using a loaner manual wheelchair until his custom wheelchair repairs could be done. Additionally, the QIDP stated that she was presently collaborating with the case manager and the interdisciplinary team to facilitate the resident's relocation to a wheelchair accessible facility.

Review of a seating clinic assessment dated August 30, 2011, on June 22, 2012, at 12:03 p.m., revealed Resident #3 would need to be moved to a wheelchair accessible house to accommodate his needs and equipment.

Team meetings have been held for both Client #3 and Client #2 to review their status and plan a move to an accessible location for both. The BRA Southern Avenue home was chosen by the individuals, and has involved family members or legal guardians and has been approved by their IDT team. The moves will be implemented by...7-30-12.

In the interim, both will continue to receive two-person assistance for transfer and mobility issues that require it to address their mobility needs...7-16-12

3. The staff members have been trained on elevating the feet of Client #2 and all other elements of the HMCP for each person supported in the home. In the future the QIDP will ensure that all staff are properly trained and aware of all elements of the HMCP for each individual in the home...7-30-12

BRA will ensure that staff new to working with client #2 are properly trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-30-12

BRA will also ensure that senior staff provide mentoring to staff new to the individuals in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment protocols...7-30-12

The QIDP and home manager will monitor compliance at minimum twice monthly (separately) to ensure ongoing compliance with the monitoring of active treatment implementation...7-30-12

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I 180

At the time of the survey, however, there was no evidence the facility's QIDP had coordinated services timely to address Resident #3's specific environmental and ambulation needs.

3. The QIDP failed to coordinate services to ensure Resident #2's legs were elevated to prevent swelling.

Observation on June 20, 2012, at approximately 5:29 p.m., revealed Staff #2 assisted Resident #2 from his bedroom to the dining room by holding his arms. As the resident took each step, he was observed slowly dragging his legs. The resident then sat in the dining room and listened to music. At 6:14 p.m., the resident remained at the table for dinner.

On June 20, 2012, at 7:12 p.m., review of an unusual incident report dated February 3, 2012, revealed the licensed practical nurse was unable to get a pulse from Resident #2's left leg. As a result, the resident was taken to the emergency room. At 7:14 p.m., review of the discharge report dated February 3, 2012, revealed Resident #2 was diagnosed with bilateral leg swelling. Further review revealed an order for Furosemide 20 mg every morning and to elevate the resident's legs.

Further observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Resident #2, was seated at the dining room table participating in table top activities. At approximately 11:30 a.m., Staff #1 walked Resident #2 around the house. As the client took each step, he was observed slowly dragging his legs. At approximately 12:00 p.m., Resident #2 sat at the dining room table for lunch. After lunch, the resident remained seated at the dining room

Client #3's wheelchair has been assessed and is scheduled for repair follow up from NRH for the missing left tipper and left brake. The necessary parts have been ordered by the vendor and repairs will be completed by ...7-30-12

Client #3 will continue to use the loaner chair in the interim. Family Home Medical has been requested to obtain a loaner chair with longer leg rests for client #3sw ...7-16-12

Team meetings have been held for both Client #3 and Client #2 to review their status and plan a move to an accessible location for both within the company. The BRA Southern Avenue home was chosen by the individuals and their involved legal guardians and has been approved by their IDT team. The moves will be implemented by...7-30-12.

In the interim, both will continue to receive two-person assistance for all transfer and mobility issues that require it to address their mobility needs until the move occurs. In the future BRA will ensure all adaptive equipment is in working or repaired in a timely manner if repairs are needed the appropriate adaptive equipment will be provided until the necessary repairs are completed...7-16-12

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table and continued to participate in table top activities with Staff #1. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the resident's lower legs were swollen.

On June 22, 2012, at 10:13 a.m., review of the medical records revealed a primary care physician note dated February 8, 2012, that instructed to elevate Resident #2's legs when sitting. On the same day, at 2:24 p.m., review of the resident's PT assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes." However, during the survey period, the facility failed to ensure that the resident's legs were elevated.

Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the resident for two weeks and had not been trained to elevate the resident's legs when sitting. Interview with LPN #2 also revealed the resident should have his legs elevated when sitting to prevent his legs from swelling.

There was no evidence that the QIDP (Staff #5) coordinated with nursing services to ensure staff training and implementation of Resident #1's recommendation for leg elevation.

I 222 3510.3 STAFF TRAINING I 222

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

This Statute is not met as evidenced by:
Based on observation, staff interview and record

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I 222	Continued From page 9 review, the group home for persons with intellectual disabilities (GHPID) facility failed to ensure staff received ongoing training to address the needs of resident, for two of three residents in the sample. (Residents #1 and #2) The findings include: 1. The facility failed to ensure each staff was trained to elevate Resident #2's legs to prevent swelling. Observation on June 20, 2012, at approximately 5:29 p.m., revealed Staff #2 assisted Resident #2 from his bedroom to the dining room by holding his arms. As the resident took each step, he was observed slowly dragging his legs. The resident then sat in the dining room and listened to music. At 6:14 p.m., the resident remained at the table for dinner. On June 20, 2012, at 7:12 p.m., review of an unusual incident report dated February 3, 2012, revealed the licensed practical nurse was unable to get a pulse from Resident #2's left leg. As a result, the resident was taken to the emergency room. At 7:14 p.m., review of the discharge report dated February 3, 2012, revealed Resident #2 was diagnosed with bilateral leg swelling. Further review revealed an order for Furosemide 20 mg every morning and to elevate the resident's legs. Further observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Resident #2, was seated at the dining room table participating in table top activities. At approximately 11:30 a.m., Staff #1 walked Resident #2 around the house. Staff #1 held the resident by his arms as he took each step with a slow drag. At approximately 12:00 p.m., Resident	I 222	3510.3 1. The staff members have been trained on elevating the feet of Client #2 and all other elements of the HMCP for each person supported. In the future the QIDP will ensure that training is done on HMCP and elements of the treatment plan outlined on a quarterly basis...7-03-12 BRA will ensure that new staff hired and any new staff working with the individuals is trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-30-12 BRA will also ensure that senior staff provide mentoring to new staff in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment protocols...7-30-12 The QIDP and home manager will monitor compliance at minimum twice monthly (separately) to ensure ongoing compliance...7-30-12 2. The QIDP retrained the staff on the program 2.B for slowing his eating pace for Client #1 aimed at reducing his eating pace. In the future the QIDP will ensure staff are re-trained on active treatment programs at least quarterly...7-05-12 A new procedure will be implemented requiring staff to read the mealtime protocol prior to beginning the meal and providing the mealtime support so that the protocol mandates are fresh in the support staff's mind. This will be done by providing each shift with a daily activity schedule that outlines what should be done on each shift for each individual...7-30-12 The QIDP and Home Manager will observe at minimum three meals weekly (separately) to ensure that proper supports are routinely provided. In the future the QIDP will ensure that mealtime observations occur weekly and train any staff as needed. On-the-spot training and/or appropriate disciplinary action will be taken as required...7-30-12	

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I 222	<p>Continued From page 10</p> <p>#2 sat at the dining room table for lunch. After lunch, the resident remained seated at the dining room table and continued to participate in table top activities with Staff #1. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the resident's lower legs were swollen.</p> <p>On June 22, 2012, at 10:13 a.m., review of the medical records revealed a primary care physician note dated February 8, 2012, that instructed to elevate Resident #2's legs when sitting. On the same day, at 2:24 p.m., review of the resident's physical therapy assessment dated March 9, 2012, revealed staff was required to "elevate his lower extremities when sitting greater than 15 minutes." However, during the survey period, the facility failed to ensure that the resident's legs were elevated.</p> <p>Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the resident for two weeks and had not been trained to elevate the resident's legs when sitting. Interview with LPN #2 also revealed the resident should have his legs elevated when sitting to prevent his legs from swelling.</p> <p>Review of the facility's training book on June 22, 2012, at 3:30 p.m., failed to provide evidence that the staff was trained to elevate Resident #2's legs as ordered.</p> <p>2. The facility failed to ensure that staff were trained to implement Resident #1's active treatment program designed to reduce his eating pace, as evidence below:</p>	I 222	

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On June 20, 2012, beginning at 6:11 p.m., Resident #1 was observed eating chopped fish, turnip greens, navy beans and pears at a fast pace. Direct support staff #3 asked the resident to slow down, but the resident continued to eat fast. At 6:15 p.m., Resident #1 drank his water and cranberry juice fast. Staff #3 asked him to slow down; but the resident continued to drink rapidly.

Review of Resident #1's individual program plan (IPP) dated December 2, 2011 on June 21, 2012, at 9:00 a.m., revealed an objective that stated, "Will slow his eating pace during breakfast lunch and dinner 100% of the time with verbal prompts for six months." Further review of the IPP revealed the following steps:

- a. The resident will pick up his fork or spoon;
- b. The resident will scoop fork or spoon into food;
- c. The resident will bring his fork or spoon to his mouth;
- d. The resident will take his food off the fork or spoon with his mouth;
- e. Resident will put fork or spoon on the plate after each mouth full;

During the mealtime observation, Staff #3 failed to prompt the resident to put his spoon on the plate to slow his eating pace.

Interview with the qualified intellectual disabilities professional (QIDP) on June 22, 2012, at approximately 3:00 p.m., revealed Staff #3 was required to prompt Resident #1 to put his spoon on his plate after each mouth full of food.

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I 222	Continued From page 12	I 222		
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At the time of the survey, the facility failed to ensure that each staff was trained to implement the Resident #1's IPP as recommended.

I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		
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Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

This Statute is not met as evidenced by: Based on observation, staff interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services were provided in accordance with the needs of one of three residents in the sample. (Resident #3)

The finding includes:

I. The GHPID failed to ensure Resident #3 received an updated assessment for loosened teeth, and treatment if indicated to maintain his dental health.

Interview with the licensed practical nurse (LPN#1) on June 21, 2012, at 5:21 p.m., revealed that Resident #3 was prescribed Chlorhexidine 12% Rinse after brushing twice daily to prevent gingivitis. Interview with the qualified intellectual disabilities professional (Staff #5) on June 22, 2012, at 10:37 a.m., revealed that Resident #3 required assistance with all activities of daily living, including tooth brushing. The QIDP further stated that staff brushed his teeth at least twice

3520.3

I. The Chlorhexidine rinse was not made available while staying at the hotel for the dates specified. In the future the medication nurse needs to ensure that all medication is available for the individual when they are away from home..../...07-19-12

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daily, and that the resident went to the dental regularly to maintain his dental health.

Review of the medication administration record (MAR) on June 21, 2012, at 5:35 p.m., revealed the resident had a current physician's order for Chlorhexidine Rinse 12 % twice daily after brushing. Further review of the medication administration record (MAR), however revealed the resident did not receive the Chlorhexidine on June 1, 2, 3, and 4, 2012 because it was "not available." Review of Resident #3's dental consultation dated September 19, 2011, on June 22, 2012, at 11:45 a.m., revealed the resident had heavy tartar and moderate bleeding. Gross debridement and prophylaxis were performed. The dentist also noted that the resident had multiple loosened teeth (#20, #24, and #25). The follow-up consultation reported dated March 19, 2012, revealed there was no further mentioning of the resident's loose teeth identified during the September 19, 2011 consultation.

Continued interview with the qualified intellectual disabilities professional (Staff #5) on June 22, 2012, at 11:47 a.m., revealed that she would follow-up with the primary licensed practical nurse (LPN #2) to determine why chlorhexidine rinse was not available for the aforementioned dates. Additionally, the QIDP indicated that she would follow up if more additional information regarding loose teeth.

Interview with LPN #2 on June 22, 2012, at 2:58 p.m., however, revealed no additional information was available.

At the time of the survey, the facility failed to ensure Resident #3's dental rinse was available to be used as prescribed. The facility also failed to ensure the resident received a follow-up

The rinse is now available with his other medication used by Client #3 in the home. In the future the medication should monitor the use of medication on a weekly basis and order as needed unless the primary care physician orders otherwise.....07-19-12

A follow-up appointment will be made for Client #3 to check the status of potentially loose teeth and the RN ensures follow-up as prescribed by the attending physician.....7-30-12

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assessment to determine the status of his previously identified loose teeth.

2. The GHPID failed to ensure nursing services were provided in accordance with the needs of Residents #1, #2, and #3.

A. Nursing services failed to ensure treatments prescribed to be done before the administration of medication were performed consistently and documented.

On June 21, 2012, beginning at 5:01 p.m., the licensed practical nurse (LPN #1) was observed to administer medications to the residents. Interview with LPN #1, during this time, revealed that the residents also received medications in the morning for blood pressure and diabetes.

Review of the medication administration record (MAR) on June 21, 2012, at 5:32 p.m., revealed circles around the nurse's initials for prescribed treatments, on several days during June 2012. The circles revealed that Residents #1, #2, and #3 had not received monitoring of blood pressures and fingersticks.

Interview with the primary licensed practical nurse (LPN #2) on June 22, 2012, at approximately 1:00 p.m., revealed that LPN #3 documented in the record that the aforementioned prescribed treatments were not done. According to LPN #2, LPN #3 should have immediately notified her; however, she learned that the treatments had not been administered "after the fact."

Further review of the residents' prescribed treatment orders on June 22, 2012, beginning at 1:12 p.m., revealed the following:

On 7/5/12, the RN held a meeting with nursing staff including those identified in the survey. Nursing is clear that blood pressures and blood sugars **MUST** be taken prior to administration of medications when ordered. When a piece of equipment is missing or not working, the nurse **MUST** call either nurse 1 or 2 immediately for guidance, replacement, or an MD order to allow administration without measurement. This was effective immediately. 7/5/12

As of 8/1/12, all nursing staff will use THERAP to document notes on all individuals so that they can be reviewed 24/7 by the RN and any concerns missed can be picked up. This does not take the place of calling nurse 1 or 2 for broken or missing equipment or other concerns that a reasonably prudent nurse would act on in notifying the supervising nurse. RN is working with nurses on using the computer system. 7-30-12 BRA will ensure that new staff to the home is trained on the specific elements of each person's training and treatment plans within 5 business days of their initial start date...7-05-12

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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) COMPLETE DATE
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I 401

(1) Resident #1 had an order for, "Metformin 500 mg , take one tablet once daily with breakfast for diabetes and to have a daily fingerstick before breakfast." Review of the "Glucose Monitoring Daily Form (in the morning before breakfast)", for June 2012, revealed no entries for June 1 and 4, 2012; "No equipment" for June 2, or 3, 2012; and "unable to perform" on June 17, 2012.

(2) Resident #1 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.)." The resident was prescribed HCTZ 25 mg each morning and Amlodipine 10 mg tab each morning for hypertension (6:00 a.m.). Review of the MAR revealed the resident was administered these medications on June 2, 2012, at 6:00 a.m., however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the resident's blood pressure was verified as prescribed prior to administering his anti-hypertension medications.

(3) Resident #2 had an order to "Monitor blood pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.). The resident was prescribed HCTZ 25 mg once daily for hypertension (6:00 a.m.). Review of the MAR revealed the resident was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the resident's blood pressure was verified as prescribed prior to administering his anti-hypertension medication.

(4) Resident #3 had an order to "Monitor blood

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1 401	<p>Continued From page 16</p> <p>pressure and pulse daily. Notify RN/MD if systolic greater than 150 and diastolic greater than one hundred (6:00 a.m.)" The resident was prescribed Lorsartan/HCTZ 100 mg/25 mg, take 1 tablet daily for blood pressure (6:00 a.m.) Review of the MAR revealed the resident was administered this medication on June 2, 2012, however the Blood Pressure Monitoring Daily form noted "Equipment not available", for that date. The facility failed to ensure the resident's blood pressure was verified as prescribed, prior to administering his anti-hypertension medication.</p> <p>At the time of the survey, there was no evidence that facility's nursing services ensured that all prescribed treatments were performed.</p> <p>B. Nursing services failed to ensure that Resident #2's legs were elevated as recommended to prevent bilateral swelling, as evidenced below:</p> <p>Observation on June 22, 2012, beginning at approximately 10:00 a.m., revealed Resident #2, was seated at the dining room table participating in table top activities until approximately 11:30 a.m., without his legs elevated. At approximately 12:00 p.m., Resident #2 sat at the dining room table for lunch and remained sitting to participate in table top activities, without his legs elevated. On the same day at 2:38 p.m., the qualified intellectual disabilities professional (QIDP), Staff #5 and the surveyor observed that the resident's lower legs were swollen.</p> <p>On June 22, 2012, at 10:13 a.m., review of a primary care physician note dated February 8, 2012, revealed it prescribed to elevate Resident #2's legs when sitting. At 2:24 p.m., review of the resident's physical therapy assessment dated March 9, 2012, revealed staff was required to</p>	1 401	

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I 401	<p>Continued From page 17</p> <p>"elevate his lower extremities when sitting greater than 15 minutes."</p> <p>Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the resident for two weeks and had not been trained to elevate the resident's legs when sitting. Interview with LPN #2 on the same day at 4:38 p.m., revealed the resident would benefit from having his legs elevated when sitting to minimize swelling.</p> <p>At the time of the survey, however, there was no evidence nursing services implemented measures to ensure Resident #2's legs were elevated as prescribed to prevent swelling.</p> <p>C. Nursing services failed to ensure that Resident #2's Ted stockings were available to be worn as recommended to prevent swelling of lower extremities.</p> <p>Interview with Staff #1 and the QIDP (Staff #5) on June 22, 2012, at 2:38 p.m., revealed Staff #1 had been working with the resident for two weeks and had not been trained to elevate the resident's legs when sitting. Interview with LPN #2 also revealed the resident should have his legs elevated when sitting to prevent his legs from swelling and that the resident should wear Ted stockings. Continued interview indicated that Resident #2's support stockings had torn and there were no more support stockings available.</p> <p>On June 22, 2012, at 12:35 p.m., review of the medical records revealed a vascular specialty report dated April 27, 2012 that stated Resident #2 has edema in his lower legs and should wear support stockings.</p>	I 401	<p>BRA will also ensure that senior staff provide mentoring to all new staff in the days before they receive their formal Phase II training and thereafter as needed to ensure they follow all routine, mandatory treatment and protocols...7-05-12</p> <p>Additionally, the Daily Activity Schedules of each person supported will be refined; the one-page document reflecting 24/7 activities and supports will be replaced by schedules for each shift (overnight, day and evening); this will allow the QIDP to provide more detailed guidance for each shift. Staff will be trained on the revised schedules and instructed to review and follow them in completing their primary duties for the shift.....7-30-12</p> <p>The RN will ensure that the HMCP outlines for staff and nursing all follow up steps for the diabetes and blood pressure issues. In the future this information will be outlined on the daily activity sheet and staff will be trained on all the additional information that has been added.....7-30-12</p> <p>The RN will ensure that the HMCP reflects strategies to address all active problems each individual has and that staff is trained on 100% of the follow up steps outlined...7-30-12</p>

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	At the time of the survey, there was no evidence the facility ensure that the resident was provided Ted stockings to manage his bilateral leg edema as recommended.			