

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

PRINTED: 08/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2012
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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4288 1/2 SOUTHERN AVE, SE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

A recertification survey was conducted from May 21, 2012 through May 23, 2012. A sample of two clients was selected from a population of three men and one female with various degrees of intellectual disabilities. In addition, a focused review was conducted of another (third) client's recent admission to the hospital. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and at three day programs, interviews with direct support staff and administrative staff, as well as a review of 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 114 483.410(c)(4) CLIENT RECORDS

Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to ensure individuals who made an entry in the client's record dated and signed it, for two of the two client's in the sample. (Clients #1 and #2)
The findings include:
1. On May 22, 2012, at approximately 12:25 p.m., review of Client #1's quarterly nursing assessments dated July 2011 and October 2011, revealed no documented evidence that the assessments had been signed or dated by the registered nurse (RN).

W 000

W 114

The nurse has added and signed a signature page for the assessments of client #1 and #2....6-12.2012

Received 6/15/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sandra Johnson, Program Director</i>	TITLE Program Director	(X6) DATE 6/15/2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114 Continued From page 1
Interview with the administrator and director of nursing (DON) on May 23, 2012, at approximately 2:35 p.m., revealed Client #1's aforementioned quarterly nursing assessments had not been signed or dated by the RN because the nurse had not included a signature page.

W 114

2. On May 22, 2012, at 2:13 p.m., review of Client #2's quarterly nursing assessments dated July 2011 and October 2011, revealed no documented evidence that the assessments had been signed or dated by the registered nurse (RN). During an interview with the DON on May 23, 2012, at approximately 2:40 p.m., it was acknowledged that Client #2's quarterly nursing assessments did not include a signature page and had not been signed or dated by the RN.

The QIDP will audit assessments once developed within 3 business days to ensure they are full, complete accurate and signed...6-12-2012

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

W 153

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all allegations of abuse were reported immediately to the administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of the three clients included in the sample. (Client #1)

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W 153	<p>Continued From page 2</p> <p>The finding includes:</p> <p>The facility failed to ensure that an allegation of abuse was reported immediately to the administrator, as evidenced below:</p> <p>On May 22, 2012, at approximately 9:35 a.m., review of an investigation report dated January 20, 2012, revealed that the assistant executive director (AED) received an anonymous call (December 19, 2011), that indicated that Staff #1 was verbally abusive toward Client #2. Further review of the investigation report revealed that the allegation of verbal abuse was substantiated.</p> <p>Interview with the AED on May 22, 2012, at approximately 10:40 a.m., verified that she received an anonymous phone call on December 19, 2011, that alleged that Staff #1 was observed to be verbally abusive toward Client #2. Further interview revealed that she immediately contacted the qualified intellectual disabilities professional (QIDP) on the same day and instructed her to remove Staff #1 from the schedule. The AED then stated that she notified the facility's administrator of the allegation of verbal abuse on December 28, 2011, eight (8) days later.</p> <p>The QIDP was interviewed on May 23, 2012, at approximately 2:05 p.m., to ascertain why the allegation of verbal abuse was not reported to the administrator on December 19, 2011. The QIDP replied by saying, "she did not know why Staff #1 was being removed from the working schedule".</p>	W 153	<p>Staff was re-trained to ensure that each understood that the administrator must be informed about all incidents immediately, particularly serious reportable incidents...6-12-12</p> <p>A protocol was developed specifically to instruct staff on reporting situations...5-30-12</p>
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported</p>	W 156	

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W 156

Continued From page 3
to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for two of the two clients residing in the facility. (Clients #1 and #4)

The findings include:

1. Review of the facility's investigative reports on May 22, 2012, at 9:35 a.m., revealed that on December 19, 2011, an anonymous caller had contacted the agency's assistant executive director (AED) alleging that Staff #1 was verbally abusive toward Client #2. Continued review of the investigation report revealed the incident management coordinator (IMC) completed the investigation on January 20, 2012. The allegation of abuse was substantiated, however, there was no documented evidence that the results of the investigation were reported or signed off by the administrator within five working days.

Interview with the assistant executive director (AED) on May 22, 2012, at approximately 10:40 a.m., acknowledged an anonymous call was received on December 19, 2011, that alleged that Staff #1 was observed to be verbally abusive toward Client #2. Interview with the IMC on May 22, 2012, at approximately 10:50 a.m., verified that the results of the investigation was not reviewed and signed off by the facility's administrator within five working days. Further

W 156

BRA ensures that incidents are reviewed and signed off by the administrator within 5 working days by reviewing all incidents in the routine weekly team meetings each Monday. The IMC ensures that the administrator's review and signature is obtained at that time if it has not been obtained prior to the team meeting ... 6-12-12
The QIDP and IMC audit all incident reports weekly to ensure routine compliance...6-1-12

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W 156	Continued From page 4 interview revealed the IMC was not considered the administrator's designee. 2. Review of an incident report dated January 6, 2012, on May 21, 2012, at approximately 9:00 a.m., alleged Staff #13 allowed Client #4 to sit in soiled clothing unattended for several hours. Review of the corresponding investigative report revealed the IMC completed the investigation on January 17, 2012. Interview with the IMC on May 21, 2012, at approximately 10:30 a.m., verified that the results of the investigation were not reviewed and signed off by the facility's administrator within five working days. Further interview revealed the IMC was not considered the administrator's designee.	W 156	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide nursing services in accordance with each client's needs, for one of one focus client. (Client #4) The finding includes: The facility's nursing staff failed to ensure Client #4 received timely medical services in accordance with the changes in the client's health status, as evidenced by: On May 21, 2012, at approximately 10:55 a.m., review of an unusual incident report dated April 4, 2012, revealed Client #4 was refusing to walk or feed himself. Further review revealed the client was transported to the emergency room for evaluation and treatment, via the facility van.	W 331	The DON will counsel the RN to ensure change of condition situations are discussed both with the DON and PCP so as that the DON and PCP have the opportunity to direct follow up based on the signs and symptoms reported ...6-12-12

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W 331 Continued From page 5

On May 22, 2012, beginning at 9:35 a.m., review of nursing progress notes revealed the following:

April 1, 2012: Direct care staff reported to the nursing staff, that Client #4 was "not standing". Further review revealed the nurse documented "no visible abnormalities noted to legs".

April 2, 2012: Direct care staff reported to the nursing staff, that Client #4 was "not standing" and stated Client #4 was able to stand before having a seizure on March 28, 2012. Staff was advised to monitor and report changes to the nurse.

April 3, 2012: It was noted by direct care staff, that Client #4 was not able to stand and had to be placed on bed to change his adult protective undergarment. During the change no pain was noted on movement when the client's lower extremities were moved and palpated. Nursing staff documented that they would re-evaluate Client #4 in the morning.

April 4, 2012: Nursing staff received a call from the direct care staff that indicated that Client #4 was not ambulating and was going to be transported to the emergency room for evaluation and x-rays. The nursing note also indicated that Client #4 was admitted to the hospital for bilateral femur fracture, etiology unknown.

Review of the hospital summary report dated May 11, 2012, on May 21, 2012, at approximately 2:30 p.m., verified Client #4 was admitted to the hospital on April 4, 2012. Further review revealed, "The client was originally seen at an outlying hospital after seizure and discharged from that hospital ER (emergency room) back to his group home. Thereafter [the resident] stayed in the bed and did not get up whereas before [the client] was able to get up with a walker. [The client] was sent to the ED (emergency department) at [this hospital], where bilateral femoral neck fracture

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W 331 Continued From page 6
were diagnosed." It is presumed that the severity of the shaking during that prior seizure was the cause of the symmetric femoral neck fractures". Review of the surgical dictation report dated May 10, 2012, on May 21, 2012, at approximately 2:35 a.m., revealed that on April 7, 2012, Client #4 had a closed reduction and internal fixation with multiple percutaneous screws to treat the bilateral femoral neck fracture.
During a telephone interview with the director of nursing (DON) on May 22, 2012, at approximately 12:05 p.m., it was indicated that when Client #4's lower extremities were moved and palpated the client did not exhibit any pain therefore, the nurse had not notified the primary care physician (PCP) of the change in Client #4's health or referred the client for medical services.

W 331

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 hold evacuation drills quarterly on all shifts, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4)

The finding includes:

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On May 21, 2012, beginning at 5:32 p.m., interview with the house manager (HM) revealed that there were three designated shifts (8:00 a.m.

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W 440	<p>Continued From page 7</p> <p>- 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on May 21, 2012, beginning at approximately 5:33 p.m., revealed that no drills were held during the weekday second shift (4:00 p.m. - 12:00 a.m.) and third shift (12:00 a.m. - 8:00 a.m.) from July 2011 through September 2011. Further review revealed there were no fire drills held during the weekend second shift (8:00 p.m. - 8:00 a.m.) over a six (6) month time frame (July 2011 through December 2011).</p> <p>Interview with the HM on May 23, 2012, at 2:40 p.m., revealed that she was aware that fire drills were not conducted during the aforementioned timeframes listed above. The HM stated that all staff had been retrained on conducting fire drills.</p>	W 440	<p>A makeup Fire Drill schedule will be developed for the next 60 days (June - July 2012) to cover the time frames missed...6-20-12</p> <p>Staff was re-trained on following the fire drill schedule and fire drill procedures...6-12-12</p> <p>The QIDP will audit the fire drill record monthly to ensure that drills are held as planned and will schedule a makeup within 5 days of any missed drill...6-20-12</p>		

Health Regulation & Licensing Administration

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1 000	INITIAL COMMENTS A licensure survey was conducted from May 21, 2012 through May 23, 2012. A sample of two residents was selected from a population of three men and one female with various degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff and administrative staff, as well as a review of 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.]	1 000	
1 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure maintenance equipment was well constructed, properly maintained, and appropriate to the function for which it is to be used, for four of four residents residing in the facility. (Residents #1, #2, #3 and #4) The finding includes: On May 23, 2012, beginning at 1:50 p.m., revealed lint was observed in the exhaust vent leading outdoors from the clothes dryer. The	1 091	

Health Regulation & Licensing Administration

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

Linda Abraham, Program Director

TITLE

(X6) DATE

6/15/2012

Health Regulation & Licensing Administration

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I 091	Continued From page 1 build-up of lint presented a potential fire hazard. The house manager (HM), who was present at the time, verified the aforementioned maintenance need. The HM stated that she would contact the facility's maintenance personnel immediately to have the lint trap cleaned.	I 091	The lint trap was cleaned...5-24-12 The lint trap will be checked daily by the home manager to ensure it is routinely cleaned...6-12-12 Staff will be retrained on maintaining the lint trap free of debris...6-20-12
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to conduct simulated fire drills quarterly on all shifts, for four of the four residents, residing in the GHPID. (Residents #1, #2, #3 and #4) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On May 21, 2012, beginning at 5:32 p.m., interview with the house manager (HM) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) for the weekend (Saturday/Sunday). Review of the GHPID's fire drill log records on May 21, 2012, beginning at approximately 5:33	I 135	A makeup Fire Drill schedule will be developed for the next 60 days (June - July 2012) to cover the time frames missed ...6-20-12 Staff was re-trained on following the fire drill schedule and fire drill procedures ...6-12-12 The QIDP will audit the fire drill record monthly to ensure that drills are held as planned and will schedule a makeup within 5 days of any missed drill...6-20-12

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I 135	Continued From page 2 p.m., revealed that no drills were held during the weekday second shift (4:00 p.m. - 12:00 a.m.) and third shift (12:00 a.m. - 8:00 a.m.) from July 2011 through September 2011. Further review revealed there were no fire drills held during the weekend second shift (8:00 p.m. - 8:00 a.m.) over a six (6) month time frame (July 2011 through December 2011). Interview with the HM on May 23, 2012, at 2:40 p.m., revealed that she was aware that fire drills were not conducted during the aforementioned timeframes listed above. The HM stated that all staff had been retrained all staff on conducting fire drills.	I 135		
I 206	3509 6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review and interview, the group home for persons with intellectual disabilities (GHPID) failed ensure one of the twelve staff provided a physician's certification. (Staff #2) The finding includes: Review of Staff #2's health certificate dated February 10, 2012, on May 23, 2012, at approximately 10:35 a.m., revealed that the PPD was read more than seventy-two (72) hours, outside the recommended window for PPD test reading. Further review revealed that the	I 206	Staff #2 will have a repeat PPD and produce an updated health certificate by...6-20-12 The QIDP will audit the personnel files at minimum quarterly to ensure they are full and complete at all times...6-20-12	

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I 206	Continued From page 3 physician recommended the PPD be repeated in one week. There was no documented evidence the PPD was repeated and that Staff #2 was certified free of communicable disease. Interview with the house manager/incident manager coordinator (HM/IMC) on May 23, 2012, at approximately 11:35 a.m., revealed Staff #2 would be removed from the schedule until the facility received documented evidence the Staff #2 was certified free of communicable disease.	I 206	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans. This Statute is not met as evidenced by: Based on record review and interview the group home for persons with intellectual disabilities (GHPID) failed to ensure one of one director of nurses (DON) and two of twelve direct care staff had current training to implement cardiopulmonary resuscitation (CPR) (DON, Staff #1 and #2) and two of twelve direct care staff had training program in first aid. (Staff #1 and #2) The findings include: 1. Review of the personnel records on May 23, 2012, beginning at 9:35 a.m., revealed the GHPID failed to have available for review current Cardiopulmonary Resuscitation (CPR) certifications for the director of nurses (DON), Staff #1 and #2. Interview with the house manager/incident	I 227	

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I 227	Continued From page 4 manager coordinator (HM/IMC) on May 23, 2012, at approximately 1:36 p.m., confirmed the DON, Staff #1 and Staff #2 did not have current CPR training on file in their personnel records. Further interview revealed Staff #1 and Staff #2 was scheduled for the aforementioned training on May 31, 2012. 2. Review of the personnel records on May 23, 2012, beginning at 9:35 a.m., revealed the GHPID failed to have available for review current first aid certifications for Staff #1 and #2. Interview with the house manager/incident manager coordinator (HM/IMC) on May 23, 2012, at approximately 1:36 p.m., confirmed Staff #1 and Staff #2 was not certified in First Aid. Further interview revealed Staff #1 and Staff #2 was scheduled for the aforementioned training on May 31, 2012.	I 227	3510.5 (d) The CPR/First Aid training scheduled for May 31, 2012 was cancelled by the trainer and rescheduled for ...6-28-12 The training record for the DON has been obtained (copy attached)...6-12-12
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review the group for persons with intellectual disabilities (GHPID) failed to ensure individuals who made an entry in the resident's record dated and signed it, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. On May 22, 2012, at approximately 12:25 p.m., review of Resident #1's quarterly nursing assessments dated July 2011 and October 2011 revealed no documented evidence that the assessments had been signed or dated by the registered nurse (RN). During an interview with the administrator and director of nursing (DON) on May 23, 2012, at	I 291	

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I 291	Continued From page 5 approximately 2:35 p.m., it was acknowledged Resident #1's quarterly nursing assessments did not have a signature page and had not been signed or dated by the RN. 2. On May 22, 2012, at 2:13 p.m., review of Resident #2's quarterly nursing assessments dated July 2011 and October 2011 revealed no documented evidence that the assessments had been signed or dated by the registered nurse (RN). During an interview with the DON on May 23, 2012, at approximately 2:40 p.m., it was acknowledged that Resident #2's quarterly nursing assessments had not been signed or dated by the RN.	I 291	The RN has added and signed a signature page for the assessments of client #1 and #2...6-12-12 The QIDP will audit assessments once developed within 3 business days to ensure they are full, complete, accurate and signed...6-12-12
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on record review and interview the group home for persons with intellectual disabilities (GHPID) failed ensure the Department of Health (DOH) was notified of an incident or event which substantially interferes with a resident's health, for two of the four residents residing in the GHPID. (Resident #2 and Resident #4) 1. On May 22, 2012, at approximately 9:35 a.m.,	I 379	

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I 379	<p>Continued From page 6</p> <p>review of an investigation report dated January 20, 2012, revealed that the assistant executive director (AED) received an anonymous call (December 19, 2011), that indicated that Staff #1 was verbally abusive toward Resident #2. Further review of the investigation report revealed that the allegation of verbal abuse was substantiated.</p> <p>Interview with the AED on May 22, 2012, at approximately 10:40 a.m., revealed that she immediately contacted the qualified intellectual disabilities professional (QIDP) on the same day of the allegation of verbal abuse. Interview with the QIDP on May 23, 2012, at approximately 2:05 p.m., revealed that the she did not report the allegation of abuse immediately to DOH.</p> <p>2. On May 21, 2012, beginning at 10:05 a.m., review of an unusual incident report dated March 29, 2012, revealed Resident #4 had a seizure lasting sixty seconds with a recovery time of fifteen minutes. Resident #4 was transported via 911 to the emergency room for evaluation and treatment. The resident was diagnosed and treated for seizure activity and released back to the group home on the same day. Further review of an unusual incident report dated April 4, 2012, revealed Resident #4 was refusing to walk or feed himself and was transported via van to the emergency room for evaluation and treatment.</p> <p>Review of the hospital summary on May 21, 2012, at approximately 2:30 p.m., revealed Resident #4 was admitted to the hospital on April 4, 2012. Further review revealed "the resident was originally seen at an outlying hospital after seizure and discharged from that hospital ER (emergency room) back to his group home. Thereafter [the resident] stayed in the bed and</p>	I 379	<p>Both the IMC and the QIDP received training to reinforce the mandate to ensure that incidents are reported to DOH the day they occur and in writing via incident report within 24 hours...6-12-12</p> <p>The administrator will review the status of follow up weekly in team management meetings (all incidents, all locations) ...6-20-12</p>

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1379	Continued From page 7 did not get up whereas before [the resident] was able to get up with a walker. [The resident] was sent to the ED (emergency department) at [this hospital], where bilateral femoral neck fracture were diagnosed. "It is presumed that the severity of the shaking during that prior seizure was the cause of the symmetric femoral neck fractures". Review of the surgical dictation report on May 21, 2012, at approximately 2:35 a.m., revealed on April 7, 2012, Resident #4 had a closed reduction and internal fixation with multiple percutaneous screws to treat the bilateral femoral neck fracture. During an interview with the house manager/incident manager coordinator (HM/IMC) on May 21, 2012, at approximately 3:00 p.m., it was acknowledged the Department of Health (DOH) was not notified of the incident which substantially interfered with Resident #4's health. Further interview revealed the HM/IMC did not notify the DOH because they were waiting for the hospital to forward Resident #4's medical records to the group home	1379	
1401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on record review and interview the Group Home for Persons with Intellectual Disabilities failed ensure professional services included both diagnosis and evaluation including identification of treatment services and services designed to prevent deterioration or further loss of function by	1401	

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1401	<p>Continued From page 8</p> <p>two of two resident's in the sample and one focus resident. (Resident #1, #2 and #4)</p> <p>The findings include:</p> <p>1. The GHPID's nursing staff failed to ensure Resident #4 received timely medical services in accordance with the changes in the resident's health status, as evidenced by:</p> <p>On May 21, 2012, at approximately 10:55 a.m., review of an unusual incident report dated April 4, 2012, revealed Resident #4 was refusing to walk or feed himself. Further review revealed the resident was transported to the emergency room for evaluation and treatment, via the GHPID van.</p> <p>On May 22, 2012, beginning at 9:35 a.m., review of nursing progress notes revealed the following:</p> <p>April 1, 2012, direct care staff reported to the nursing staff, Resident #4 was "not standing". Further review revealed the nurse documented "no visible abnormalities noted to legs".</p> <p>April 2, 2012, direct care staff reported to the nursing staff, Resident #4 was "not standing" and stated Resident #4 was able to stand before having a seizure on March 28, 2012. Staff was advised to monitor and report changes to the nurse.</p> <p>April 3, 2012, it was noted by direct care staff, Resident #4 was not able to stand and had to be placed on bed for diaper change. During change no pain was noted on movement when lower extremities were moved or palpated. Nursing staff documented that they would re-evaluate Resident #4 in the a.m.</p> <p>April 4, 2012, nursing staff received a call from the direct care staff that indicated that Resident #4 was not ambulating and was going to be transported to the emergency room for evaluation and x-rays. The nursing note also was admitted to the hospital for bilateral femur fracture, etiology unknown.</p>	1401	<p>The DON will counsel the RN to ensure change of condition situations are discussed both with the DON and PCP so as that the DON and PCP have the opportunity to direct follow up based on the signs and symptoms reported...</p> <p>6-12-12</p>

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I 401	Continued From page 9 Review of the hospital summary dated May 11, 2012, on May 21, 2012, at approximately 2:30 p.m., revealed Resident #4 was admitted to the hospital on April 4, 2012. Further review revealed, "The resident was originally seen at an outlying hospital after seizure and discharged from that hospital ER (emergency room) back to his group home. Thereafter [the resident] stayed in the bed and did not get up whereas before [the resident] was able to get up with a walker. [The resident] was sent to the ED (emergency department) at [this hospital], where bilateral femoral neck fracture were diagnosed." It is presumed that the severity of the shaking during that prior seizure was the cause of the symmetric femoral neck fractures". Review of the surgical dictation report dated May 10, 2012, on May 21, 2012, at approximately 2:35 a.m., revealed that on April 7, 2012, Resident #4 had a closed reduction and internal fixation with multiple percutaneous screws to treat the bilateral femoral neck fracture. During a telephone interview with the director of nursing (DON) on May 22, 2012, at approximately 12:05 p.m., it was revealed that on April 3, 2012, Resident #4 appeared to be alert, active and talkative and when Resident #4's lower extremities were moved and palpated no pain was noted on movement. Further interview revealed the nurse had planned to re-evaluate the resident on April 4, 2012.	I 401		