

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

PRINTED: 04/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 369	Continued From page 9 meals. Starting on May 6, 2013, the POS specified a 6:30 a.m. administration time; and, 3. The Hydrocortisone 1% cream had been discontinued, effective January 29, 2014 On April 2, 2014 at 10:15 a.m., in the absence of LPN #1, the facility's QIDP was informed of the aforementioned findings. At 10:32 a.m., after having reviewed the MAR's, the medication bubble pack, and the POS, the QIDP confirmed the errors and further stated that he would submit an incident report. LPN #1 returned to the facility on April 2, 2014. At 2:07 p.m., LPN #1 stated that the 40 milligrams of Famotidine, Hydrocortisone 1% cream, and Levothyroxine 88 mg tablet were administered because she had found them in the basket that held the client's morning medications. She and the QIDP presented the client's evening medications, which were routinely stored in a plastic bag. Further interview with LPN #1 revealed that the pharmacy used to apply color coded stickers to the bubble packs. The colored stickers helped distinguish between morning and evening medications. At the conclusion of the interview, LPN #1 was observed speaking with the pharmacist by telephone; she was requesting that the color system be reinstated. At the time of the survey, three errors were observed during the morning medication administration process.	W 369	W 369 - An incident report was filed pertaining the incident. All relevant parties were informed of the medication errors. - The facility's RN has in-serviced all LPNs and TMEs on the "Five Rights of Medication Administration." Emphasis during the in-service was put on adhering to physician's orders. - LPN#1 will be observed three times (once every month) by the facility's RN to ensure compliance with guidelines of medication administration.	04/03/14 04/10/14 04/15/14	

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 2, 2014 through April 3, 2014. A sample of two residents was selected from a resident population of four men with varying degrees of intellectual disabilities. A focused review was conducted of a third resident's behavior support needs due to observations made on the evening of April 2, 2014. The findings of the survey were based on observations, interviews and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Behavior Support Plan - BSP Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID House Coordinator - HC Individual Program Plan - IPP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Milligrams - mg Ounce - oz Primary Care Physician - PCP Physician's Orders - POS Qualified Intellectual Disabilities Professional - QIDP	I 000			
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.	I 422			

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Markin

TITLE

Adm. Asst.

(X6) DATE

4-28-14

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COMP CARE II

**1321 EMERSON STREET NW
WASHINGTON, DC 20011**

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I 422	Continued From page 1 This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID staff failed to implement each resident's self-medication administration training program and BSP that were included in ISPs, for three of four residents of the facility. (Residents #1, #2 and #3) The findings include: I. Facility nurses did not consistently implement Resident #1's and #2's self-medication training programs, as follows: a. On April 2, 2014 at approximately 7:33 a.m., LPN #1 was observed punching all of Resident #1's medications into a pill cup. After punching the medications, LPN #1 placed the medication cup to Resident #1's mouth. After Resident #1 swallowed his medications, LPN #1 placed a cup of water to Resident #1's mouth. Resident #1 drank about 4 oz of water and then sat at the dining room table for breakfast. b. On April 2, 2014 at approximately 8:05 a.m., LPN #1 was observed punching all of Resident #2's medication into a pill cup. After punching the medications, LPN #1 placed the medication cup to Resident #2's mouth. After Resident #2 swallowed his medications, LPN #1 placed a cup of water to Resident #2's mouth. Resident #2 drank about 3 oz of water and then sat at the dining room table for breakfast. On April 2, 2014 at approximately 9:06 a.m., interview with LPN #1 revealed that Resident #1 and Resident #2 had self-medication administration programs. When asked the circumstances that prevented the program from	I 422		

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I 422	Continued From page 2 being implemented that morning , LPN #1 revealed "Nothing, I just forgot about the self-medication programs today and the QIDP usually does the programs in the evening." On April 3, 2014 at 11:00 a.m., review of Resident #1's IPP dated March 2014, revealed a self-medication administration training program . The program included: "With verbal prompts , <Resident #1's name> will punch his medication during the medication administration , 60% of all opportunities for six consecutive months ." The tasks outlined included: -<Resident #1> will wash his hands -Go to a private area -Hold the medication cup -Identify medications to be punched -Punch medications in a pill cup -Drink medication with a glass of water Similarly, on April 3, 2014 at 3:00 p.m., review of Resident #2 's IPP dated March 2014, revealed a self- medication administration training program . The program included: "With physical assistance, <Resident #2's name> will punch his medications from a blister pack to a cup 60% of recorded trials per month ." The tasks outlined included: -<Resident #2> will wash his hands -Go to a private area -Identify medications to be punched -Hold the medication cup -Punch medicine -Drink medicine (sic) On April 2, 2014, observations at 7:33 a.m. and 8:03 a.m., revealed that LPN #1 did not provide Resident #1 and Resident #2 the opportunity to	I 422			

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I 422	Continued From page 3 implement their program objectives in accordance with their IPPs. II. Facility staff failed to implement Resident #3's BSP, as follows: On April 2, 2014, at approximately 5:35 p.m., Resident #3 was observed seated in the dining room, awaiting his dinner. At approximately 5:40 p.m., the resident stood up and walked into the living room. At 5:42 p.m., Resident #3 was observed to let out a shriek and removed his T-shirt. The resident flung the T-shirt across the living room. At 5:46 p.m., the resident began shrieking again. DSP #1 approached him and began removing the resident's shoes while the resident sat on a love seat. The resident had a very upset look on his face. Initially, he swung his fist at DSP #1 but quickly allowed the staff to remove the shoes. At approximately 5:47 p.m., Resident #3 stood up, walked across the living room to another love seat, removed his pants (brown, corduroy) and sat down on the love seat. He was no longer wearing any clothes. DSP #1 approached Resident #3 with the corduroy pants and attempted to put them back on. The resident shrieked continuously, kicking his legs and he had a very upset facial expression. DSP #1 continued trying to put the pants back on but the shrieking continued and the resident swung his fists at him. The HC and DSP #2 were looking on from the dining room but did not get involved. At approximately 5:48 p.m., a maintenance man, Staff #3, came in through the facility's front door. When he observed DSP #1 was not to able to put the corduroy pants on Resident #3, he	I 422	I 422 (I) - All Licensed Practical Nurses (LPNs) and Trained Medication Employees (TMEs) of the facility have be in-serviced on implementation of self-medication goals. - The facility's Registered Nurse (RN) will on a monthly basis work collaborative with the Qualified Intellectual Disabilities Professional (QIDP) in observing the nurses during medication pass so as to ensure that self-medication goals are implemented as outlined. - The facility's RN will quarterly train LPNs and TMEs on implementation of self-medication goals		04/10/14 04/10/14 04/30/14

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I 422	Continued From page 4 walked into the living room and offered assistance. Staff #3 attempted to put the pants on the resident; however, Resident #3 shrieked loudly and refused to cooperate. Staff #3 handed the corduroy pants back to DSP #1, shook his head and said something to the effect of "good luck." DSP #1 left the room briefly then returned carrying a pair of grey sweat pants. When the HC observed DSP #1 trying to put the sweat pants on Resident #3, she instructed the staff to "give him time." The staff moved approximately 4 feet away from Resident #3, who remained naked and seated in the living room. The HC was then observed asking Resident #3 if he wanted ice cream. The resident remained seated on the love seat, without responding. At 5:52 p.m., Resident #3 stood up and walked out of the living room. DSP #1 followed the resident into the front foyer, carrying the sweat pants. Loud shrieks were heard coming from the bathroom. At 5:55 p.m., Resident #3 went into the dining room and took a seat at the table. He was wearing the sweat pants, with no shirt or shoes. Although the resident had stopped shrieking, he had an upset look on his face. At 5:56 p.m., Resident #3 shrieked, stood up from the table and walked into the living room. Approximately one minute later, he went upstairs to his bedroom and DSP #1 followed. On April 3, 2014, beginning at 12:55 p.m., the QIDP was interviewed about Resident #3's behavior. He confirmed that disrobing in public was a targeted maladaptive behavior, which was addressed in the resident's BSP. The QIDP stated that the resident was allowed to remove his clothes while in the comfort of his home. He further explained that staff had been instructed to	I 422			

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I 422	Continued From page 5 respect the resident's rights and not try to force him to wear clothes. On April 3, 2014, beginning at 1:28 p.m., review of Resident #3's BSP dated October 25, 2013, revealed that it addressed two targeted maladaptive behaviors: repetitive removal of clothing items (i.e. shoes, shirts, pant etc.) and physical aggression (striking, hitting or kicking at staff or peers). The BSP indicated the resident "should be able to remove his shirt or shoes at home so that he feels more comfortable ... Other clothing must remain on his body outside of a private setting so that he is not exposed to anyone." Continued review of the BSP revealed: "Role play and modeling should be used to teach and support <resident's name> in understanding what appropriate forms are and in what settings ... Staff response to repeated removal of clothing: provide verbal redirection ...; ask <resident's name> what is causing his displeasure with wanting to take off his clothing; assess <resident's name> for any discomfort that he may be feeling ...; assess <resident's name> for skin dryness and notify the nurse of irritation; ... support him and be encouraging that demonstrates understanding of his difficulties. Acknowledge his discomfort and communicate with him." Observations revealed that staff did not implement the strategies outlined in Resident #3's BSP, when he disrobed in a common area (living room) beginning at 5:47 p.m. on April 2, 2014. At the time of the survey, the GHIID failed to show evidence that each resident's active treatment goals and objectives were	I 422	I 422 (II) - All Direct Support Professionals (DSPs) have been trained on implementation of Client #3's Behavior Support Plan (BSP). Emphasis of the train was on implementation of proactive strategies and interventions outlined in Client #3's BSP. - The facility's House Manager (HM) and the QIDP will on a weekly basis observe and guide staff during implementation of Client #3's BSP so as to ensure compliance with stipulated proactive strategies and interventions.	04/15/14 04/15/14

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I 422	Continued From page 6 implemented as written.	I 422			
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHIID failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of the four residents of the facility. (Residents #2 and #3) The findings include: I. [483.460(k)(2)] The GHIID failed to ensure Resident #2's right to receive medications in accordance with physician's orders, as follows: [Cross-refer to Federal Deficiency Report - Citation W368] On April 2, 2014, the morning medication nurse, LPN #1, arrived at the facility at 7:30 a.m. Moments later, she instructed staff to keep Residents #1 and #2 from eating breakfast until after they received their medications. Beginning at 8:03 a.m., LPN #1 was observed administering Resident #2 Famotidine 40 mg and Levothyroxine 88 mg. At 8:17 a.m., immediately after the medication pass, Resident #2 was observed eating breakfast. At 8:50 a.m.,	I 500			

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I 500	Continued From page 7 after all of the residents' medications had been administered, LPN #1 stated that she typically arrived at the facility between 6:50 a.m. - 7:00 a.m., adding that nothing had been out of the ordinary that morning. On April 2, 2014, at 9:50 a.m., review of Resident #2's POS for April 2014 revealed the following errors: A. The Famotidine 40 mg was to be administered at "bedtime;" and, B. The Levothyroxine 88 mg was to be administered 30 minutes before (or 2 hours after) meals. Starting on May 6, 2013, the resident's POS had specified a 6:30 a.m. administration time. On April 2, 2014 at 10:32 a.m., after having reviewed the MAR's, the medication bubble pack, and the POS, the QIDP confirmed the errors. LPN #1 returned to the facility on April 2, 2014. At 2:07 p.m., LPN #1 stated that the Fomatidine was administered because she had found it in the basket that held the resident's morning medications. She recalled having asked staff to keep Resident #2 from eating breakfast until after he received his medications. She did not address the issue of a 30-minute absorption period. II. The GHIID failed to ensure Resident #3's right to dignity and privacy, as follows: [Cross-refer to I422.II] On April 2, 2014, at 5:47 p.m., Resident #3 was observed to remove his	I 500	I 500 (I) - An incident report was filed pertaining the incident. All relevant parties were informed of the medication errors. - The facility's RN has in-serviced all LPNs and TMEs on the "Five Rights of Medication Administration." Emphasis during the in-service was put on adhering to physician's orders. - LPN#1 will be observed three times (once every month) by the facility's RN to ensure compliance with guidelines of medication administration.		04/03/14 04/10/14 04/15/14

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I 500	Continued From page 8 pants (brown, corduroy) in the facility's living room. Having already removed his T-shirt, shoes and socks, the resident was now fully unclothed. A direct support staff (DSP #1) and a maintenance man (Staff #3) made several attempts to put the pants back on but the resident refused to cooperate. The house coordinator (HC #1) and another direct support staff (DSP #2) looked on from the dining room. The resident walked out of the living room at 5:52 p.m. No staff was observed attempting to shield the resident (visually) from public exposure for 5 minutes. On April 3, 2014, beginning at 12:55 p.m., the QIDP was interviewed about Resident #3's behavior. The QIDP stated that the resident's BSP allowed for the resident to remove his clothes while in the comfort of his home. He further explained that staff had been instructed to respect the resident's rights and not try to force him to wear clothes. The QIDP replied "no" when asked if there were procedures GHIID staff should use to protect Resident #3's dignity and privacy if/when the resident removed his pants and underpants while in common areas of the home, such as the living room. On April 3, 2014, beginning at 1:13 p.m., review of Resident #3's psychological assessment, dated October 25, 2013, revealed the resident functioned in the profound range of intellectual disability (cognitive and adaptive). The psychologist determined the resident was "unable to make independent decisions concerning his ... treatment plan ... lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give informed consent ... <Resident #3's	I 500			

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I 500	Continued From page 9 name> is, however, able to make simple choices among appropriate alternatives and should be given every opportunity to do so ...relate to matters such as clothing, activities, snacks ... and socializing opportunities. On April 3, 2014, beginning at 1:28 p.m., review of Resident #3's BSP, dated October 25, 2013, revealed that it addressed the behavior of repetitive removal of clothing items (i.e. shoes, shirts, pant etc.). The BSP indicated he "should be able to remove his shirt or shoes at home so that he feels more comfortable ... Other clothing must remain on his body outside of a private setting so that he is not exposed to anyone." The BSP instructed staff to provide "verbal redirection," ask the resident if he was experiencing discomfort, assess his skin for dryness and offer him words of support and understanding. The BSP did not, however, provide instructions regarding how staff should ensure that his private body parts were not exposed. Observations on April 2, 2014 revealed no evidence that the GHIID had established and/or implemented policies and procedures to ensure Resident #3's dignity and right to privacy.	I 500	I 500 (II) - An incident report was filed pertaining the incident. All relevant parties were informed of the medication errors. - The facility's RN has in-serviced all LPNs and TMEs on the "Five Rights of Medication Administration." Emphasis during the in-service was put on adhering to physician's orders. - LPN#1 will be observed three times (once every month) by the facility's RN to ensure compliance with guidelines of medication administration.	04/03/14 04/10/14 04/15/14