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

PRINTED: 07/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
09G152		B. WING	· · · · · · · · · · · · · · · · · · ·	07/18/2013		
NAME OF PROVIDER OR SUPPLIER COMP CARE I I				STREET ADDRESS, CITY, STATE, ZIP COD 1000 NEWTON STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs	W 000			
	17, 2013 through Ju clients was selected females with varying disabilities. This su	rvey was conducted from July uly 19, 2013. A sample of two d from a population of two g degrees of intellectual rvey was initiated utilizing the	4	Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002		Commonwell of County of Management (
	fundamental survey process. The findings of the survey were based on		×	W 189 - Licensed Practical 1	Nurse	
	observations in the home and at two day programs, interviews with direct support staff,		#1 (LPN #1), Train	ed		
	nursing and administrative staff, as well as a review of client and administrative records,			Medication Employ	rees	
	including incident reports.		(TMEs), and other	LPNs		
	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual			of the facility have		
W 189	disabilities professional (QIDP) within this report.]	144 400	trained on the facili	ty's		
VV 109			W 189	policy and procedur		1
			regarding medication			
			disposal. The training	ıg		
# # # # # # # # # # # # # # # # # # #	,,			focused on adhering		
	This STANDARD is	not met as evidenced by:		physician's orders, l		
1	review, the facility fa	led to ensure staff was		dispose of medication	on,	5 1
	effectively trained to outlined in the medic	manage the provisions ation policies and		communication with	the '	
	procedures for one of sample. (Client #1)	f the two clients in the		Registered Nurse (R	N)	
	The finding includes:			and primary care		
				physician to inform	them	
		7:31 p.m., Client #1's floor as licensed practical		of disposed medicat	ion.	8/07/13
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	A 1 TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G152			(X2) MULTIPLE CONSTRUCTION A. BUILDING			The state of the state of	(X3) DATE SURVEY COMPLETED	
		B. WING				07/18/2013		
COMP CARE I I (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	10 W	REET ADDRESS, CITY, STATE, ZIP CODE 100 NEWTON STREET NE (ASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
			IAG	17 (\$	DEFICIENCY)	NAIL	1 12	
W 189	nurse (LPN) #1 adr medications. LPN # from the bubble par to administer the m #1 received her Ibu another one from the LPN #1 at 7:35 p.m medication falls to the to put the medication the medication cabi not available, therefore medication on a shead On July 18, 2013, as review of the medication revealed LPN #1 wand Nurse #1 when a madisposed. On July 18, 2013, as interview with Regist LPN #1 did not infort of medications, therefore the training record p.m., failed to evider	ministered the client's f1 punched another Ibuprofenck, but it fell as he attempted edication. At 7:33 p.m., Client profen after LPN #1 punched he bubble pack. Interview with, revealed that when a he floor, the nurse is required on in a red box and lock it in net. However, a red box was fore LPN #1 place the elf in the medication cabinet. It approximately 3:00 p.m., ation policies and procedures as required to call Registered edication needed to be It approximately 3:30 p.m., tered Nurse #1 revealed that me her of the need to dispose effore the primary care offied. Further interview ould retrain LPN #1. Review do no July 18, 2013, at 1:00 nee that LPN #1 was trained a medication needed to be	W 1	89	W 189 Cont. - The facility's RN will a quarterly basis train to nursing staff and Train Medication Employees (TMEs) on issues pertaining to medication administration, documentation, communication, adhering to medication orders, and other nursing domains related to the LPNs and TMEs.	he ed n	08/07/13	
W 247	that all LPN's comm nurse in accordance and procedures. 483.440(c)(6)(vi) INI	y, the facility failed to ensure unicated with the registered with the medication policies	W 24	7				
	The individual progra opportunities for clie	am plan must include nt choice and						

PRINTED: 07/30/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 09G152 B. WING 07/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE COMP CARE II WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 247 Continued From page 2 W 247 W 247 self-management. Staff have been trained on how to adequately support This STANDARD is not met as evidenced by: Client #1 during meals, Based on observation, record review and interview, facility staff failed to consistently adhering to Client #1's encourage clients to eat independently, for one of two clients in the sample. (Client #1) mealtime protocol, and The finding includes: implementation of During dinner observations on July 17, 2013, at Individual Program Plan 5:21 p.m., Client #1 took her plate to the dining (IPP) as specified. room table. At 5:22 p.m., Staff #2 began to spoon 08/07/13 feed Client #1 with a regular teaspoon. At 5:26 p.m., Staff #1 took the teaspoon from staff #2 and began to spoon feed Client #1. At 5:27 p.m.. The facility's House Client #1 consumed her beverage independently. By contrast, observation at the day program on Manager (HM) will on a July 18, 2013, beginning at 12:20 p.m., revealed Client #1 was eating her lunch with a build up weekly basis observe staff handle spoon as day program staff #1 verbally during meals and active prompted her. At 12:31 p.m., Client #1 stopped feeding herself, therefore day program #1 began treatment implementation to spoon feed her with hand over hand assistance. to ensure that staff are On July 18, 2013, at 11:40 a.m., review of Client adhering to Client #1's #1's occupational therapy assessment dated June 28, 2013, revealed "Staff to continue to mealtime guidelines, encourage [Client #1] to participate in

eating/feeding herself during meals. If she does not show interest in feeding herself, staff will use

hand-over-hand assistance in supporting [Client #1] during meals." Continued review revealed

Client #1 uses a teaspoon to eat her meals.

On July 18, 2013, at approximately 4:30 p.m., interview with Staff #2 revealed that Client #1

08/13/13

following the diet orders

for Clients #1 and #2, and

implementation of IPP

goals.

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was no pharmacy review between December 12,

2. Medication administration observation on July

2012 through May 27, 2013 (5 months).

17, 2013, at 7:47 p.m., revealed Client #2 received Lovastatin and Singulair. Review of Client #2's medical record on July 18, 2013, at 3:04 p.m., revealed there was no pharmacy review between December 12, 2012 through May 08/15/13

review dates, and keeping

up with the quarterly

schedule.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G152	B. WING_		07/18/2013	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
W 362	July 17, 2013, at an revealed the pharm clients drug regime interview revealed	nsed Practical Nurse #2 on opproximately 3:15 p.m., nacist is required to review the n every quarter. Further that she was not aware that	W 36	W 368		
W 368	At the time of the sign provide evidence the quarterly reviews as 483.460(k)(1) DRU The system for drug that all drugs are as the physician's order	urvey, the facility failed to lat a pharmacist conducted s required. G ADMINISTRATION g administration must assure dministered in compliance with	W 36	- Licensed Practical N #1 (LPN #1), Trained Medication Employe	d ees PNs een	
2	Based on observat review, the licensed to ensure that each administered in comorders, for one of tw facility. (Client #2) The finding includes On July 17, 2013, at Ketoconazole sham p.m., LPN #1 placed When asked, LPN # the client's feet beca 7:55 p.m., (13 minut #2's feet out of the p	ion, interview and record practical nurse (LPN) failed client's prescribed drugs were apliance with physician's to clients residing in the		to medication administration, and implementing orders a outlined. The facility's RN will a quarterly basis in- service nurses and TM on the guidelines to medication administra	as	

[^] DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G152	B. WING		07/	18/2013
NAME OF PROVIDER OR SUPPLIER COMP CARE I I				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 368	Continued From pa slippers.		W 368			
	client's physician's of medication administ July 1, 2013, reveals #2's feet with Ketoo minutes once a day that the MAR was sindicating that the content of Ketoconazole shame. During an interview at approximately 8:3 soaked Client #2's feet for 20 minutes as provided to 483.460(k)(2) DRUCT The system for drug that all drugs, included self-administered, and This STANDARD is Based on observation of the facility. (Client of July 17, 2013, at Ketoconazole shame)	with LPN #1 on July 17, 2013, 30 p.m., LPN #1 stated he eet for 20 minutes If, the facility LPN failed to with Ketoconazole shampoo escribed. ADMINISTRATION administration must assure ing those that are re administered without error. not met as evidenced by: on, interview and record practical nurse (LPN) failed client medications were scribed, for one of two clients it #1)	W 369			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		09G152	B. WING		07/18/2013		
NAME OF PROVIDER OR SUPPLIER COMP CARE II				1000 NEW	DDRESS, CITY, STATE, ZIP CODE /TON STREET NE GTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETI	ON
W 369	the client's feet bed 7:55 p.m., (13 minu #2's feet out of the towel before placing slippers. On July 17, 2013, a client's physician's emedication adminis July 1, 2013, reveal #2's feet with Ketominutes once a day that the MAR was sindicating that the c Ketoconazole sham During an interview at approximately 8:3 soaked Client #2 feet At the time of surverse.	#1 stated that he was soaking ause she has foot fungus. At ites later) LPN #1 took Client pale and dried them with a gethe client's feet back in her it 8:25 p.m., review of the order sheets (POS) and tration review (MAR) dated ed an order to soak Client conazole shampoo for 20 c. Continued review revealed igned for July 17, 2013, lient's feet was soaking with apoo for 20 minutes. with LPN #1 on July 17, 2013, 30 p.m., LPN #1 stated he et for 20 minutes y, the facility LPN failed to the with Ketoconazole shampoo	W 3	69 W 3	Jicensed Practical Nursell (LPN #1), Trained Medication Employees (TMEs), and other LPN of the facility have been trained on adhering to physician's orders, following the guidelines to medication administration, and implementing orders as outlined. The facility's RN will or a quarterly basis inservice nurses and TME on the guidelines to medication administration.	08/07/13	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: HFD03-0128 07/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE COMP CARE II WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure survey was conducted from July 17, 2013 through July 18, 2013. A sample of two residents was selected from a population of two females with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, nursing 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.] I 090 Resident #1's closest door 1090 3504.1 HOUSEKEEPING 1090 knob has been replaced. 07/18/13 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, The microwave has been and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable 07/20/13 replaced. odors. The maintenance division of the facility will on a This Statute is not met as evidenced by: Based on observation and interview, the group monthly basis conduct home for individuals with intellectual disabilities (GHIID) maintained the interior and exterior of the interior and exterior facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following environmental inspections observations, for two of the two residents residing to ensure compliance with in the facility. (Residents #1 and #2) State and Federal The findings include: 08/07/13 guidelines. Observation during the inspection of the environment on July 18, 2013, beginning at 4:57 Health Regulation & Licensing Administration

Health Regulation & Licensing Administration

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

TITLE

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Health H	Regulation & Licensin	ig Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD03-0128	B. WING		07/18/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
сомро	ADEII	1000 NEV	VTON STREE	ET NE	
COMIT	ANLII	WASHING	STON, DC 20	0019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
1090	Continued From pa	ge 1	1 090		
	p.m., revealed the f	ollowing:		I 420	
	1. Resident #1's clo	set door knob was broken.		 Staff have been trained 	on
	CONTROL OF A STATE OF			how to adequately supp	oort
	2. The interior of the	e microwave was peeling.		Client #1 during meals,	
		nager (HM #1) who was present conmental inspection, stated she the aforementioned concerns.		adhering to Client #1's	
				mealtime protocol, and	
1 420	3521.1 HABILITATI	ON AND TRAINING	1420		
1 120			1420	implementation of	
		provide habilitation and nts to enable them to acquire		Individual Program Pla	n
	and maintain those	life skills needed to cope		(IPP) as specified.	08/07/13
		the demands of their achieve their optimum levels			
		and social functioning.		- The facility's House	
		met as evidenced by: on, interview and record		Manager (HM) will on	a
1 1 1 1	review, the group ho	ome for individuals with		weekly basis observe st	aff
		es (GHIID))failed to ensure ing to its residents to enable		during meals and active	,
	them to acquire and	maintain those life skills		treatment implementation	
	demands of their en	e effectively with the vironments and to achieve		to ensure that staff are	
		of physical, mental and or one of two residents in the			
	sample. (Resident #			adhering to Client #1's	
	The finding includes			mealtime guidelines,	
į	During dinner obser	vations on July 17, 2013, at		following the diet order	s
1	5:21 p.m., Resident#	1 took her plate to the dining		for Clients #1 and #2, a	nd
		o.m., Staff #2 began to spoon ha regular teaspoon. At 5:26		implementation of IPP	
	p.m., Staff #1 took th	ne teaspoon from staff #2 and Resident#1, At 5:27 p.m.		goals.	08/13/13

F36311

PRINTED: 07/30/2013 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING HFD03-0128 07/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE COMP CARE II WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1420 1 420 Continued From page 2 Resident #1 consumed her beverage independently. By contrast, observation at the day program on July 18, 2013, beginning at 12:20 p.m., revealed Resident #1 was eating her lunch with a build up handle spoon as day program staff #1 verbally prompted her. At 12:31 p.m., Resident #1 stopped feeding herself, therefore day program #1 began to spoon feed her with hand over hand assistance. On July 18, 2013, at 11:40 a.m., review of Resident #1's occupational therapy assessment dated June 28, 2013, revealed "Staff to continue to encourage [Resident #1] to participate in eating/feeding herself during meals. If she does not show interest in feeding herself, staff will use hand-over-hand assistance in supporting [Resident #1] during meals." Continued review revealed Resident #1 uses a teaspoon to eat her meals. On July 18, 2013, at approximately 4:30 p.m., interview with Staff #2 revealed that Resident #1 should be provided the opportunity to feed herself. Further interview revealed that going forward; she would provide Resident #1 with the opportunity to feed herself.

Health Regulation & Licensing Administration STATE FORM

1473 3522.4 MEDICATIONS

the prescribing physician.

At the time of the survey, facility staff failed to allow clients to exercise their independence.

irregularities in the resident's drug regimens to

The Residence Director shall report any

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

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1473

Hoalth F	Pogulation & Liconsin	a Administration			PRINTED: 07/30/20 FORM APPROVE
Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 100	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HFD03-0128			B. WING		07/18/2013
NAME OF F	PROVIDER OR SUPPLIER	1000 NEV	ODRESS, CITY, VTON STRE GTON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	LD BE COMPLETE
I 473	intellectual disabilitie	ge 3 ome for individuals with es (GHIID) failed to ensure eccived medications as	1 473	I 473	
100		of two residents in the facility.		- Licensed Practical No #1 (LPN #1), Trained	i
	On July 17, 2013, at Nurse (LPN) #1 mix a pale of water. At 7 Client #2's feet in the stated that he was s because she has for minutes later) LPN # the pale and dried th	2.7:41 p.m., Licensed Practical ed Ketoconazole shampoo in 2.42 p.m., LPN #1 placed e pale. When asked, LPN #1 oaking the client's feet of fungus. At 7:55 p.m., (13 fet took Client #2's feet out of them with a towel before eet back in her slippers.		Medication Employed (TMEs), and other LI of the facility have be trained on adhering to physician's orders, following the guidelir	PNs een
	On July 17, 2013, at client's physician's o medication administration 1, 2013, revealed #2's feet with Ketocominutes once a day. That the MAR was significating that the cliketoconazole shamp.	8:25 p.m., review of the order sheets (POS) and ration record (MAR) dated an order to soak Client conazole shampoo for 20 Continued review revealed gned for July 17, 2013, ent's feet was soaking with the poor for 20 minutes.		to medication administration, and implementing orders a outlined. The facility's RN will a quarterly basis in-	08/07/13 on
	2013, at approximate	ely 8:30 p.m., LPN #1 stated s feet for 20 minutes		service nurses and TM on the guidelines to	lEs

20 minutes as prescribed.

At the time of survey, the facility failed to soak Client #2's feet with Ketoconazole shampoo for

08/07/13

medication administration.