

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

PRINTED: 10/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2011
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

W 000

A re-certification survey was conducted from 9/20/2011 through 9/22/2011. A random sampling of two clients was selected from a population of four individuals with varying degrees of intellectual and developmental disabilities.

This re-certification was completed utilizing the fundamental survey process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services for one of the two clients in the sample. [Client #2]

The finding includes:

The QIDP failed to coordinate Client #2's PT services to ensure the development and implementation of a range of motion program, as follows:

Observation on 9/20/2011, beginning at 1:00 p.m., revealed Client #2 walked slowly and was

Received 10/12/11

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

See responses to W 159 on page 2 of 6.

LABORATORY DIRECTOR'S SIGNATURE OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	DATE
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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 the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 159	Continued From page 1 very unsteady at times as she moved around her environment. Review of Client #2's medical records on 9/21/2011, at 10:27 a.m., revealed her 4/8/2010 Physical Therapy Evaluation assessed her "decreased range of motion of the ankles and weakness are related to an increase in risk for fall." Further review of the PT assessment revealed the recommendation that the facility "Set up an exercise and range of motion program to address ankle range of motion and general decreased strength (therapist to set up and in-service staff)." Interview with the QIDP on 9/21/2011, at 1:05 p.m., revealed the PT had yet to set-up the range of motion program for Client #2's ankle. Further record review confirmed there was no evidence that the range of motion program for Client #2's ankle had been put in place.	W 159	W159 The QIDP in conjunction with the delegating RN has scheduled client # 2 for a physical therapy re-evaluation at [REDACTED] Upon receipt of the assessment based on client #2 current PT needs, recommendations will be implemented and all staff will be trained on recommendations from PT. Periodic observation will be done by program manager/QIDP to ensure compliance and provide technical assistance as needed. In cases when staff failed to carry out recommendations, staff will be retrained and corrective action may be taken.	10-31-11 Ongoing 9/23/11 & 10/11/11 Ongoing	
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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all prescribed medications were administered in accordance with clients' physician orders, for one of the four clients residing in the facility. [Client #3] The finding includes: On 9/20/2011, at 7:44 a.m., Client #3 was observed walking from her bedroom to the	W 368	See responses to W 368 on page 3 of 6.		

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W 368	<p>Continued From page 2</p> <p>nurse's desk in the office. At 7:50 a.m., the morning medication nurse (a licensed practical nurse, LPN) administered Client #3's medications. At 7:52 a.m., the client went to the dining room and began eating her breakfast. She was observed to finish her meal at 8:10 a.m.</p> <p>On 9/20/2011, at 4:56 p.m., review of Client #3's physician's order sheets (POS) dated September 2011, revealed the physician ordered "Levothyroxine Sodium 125 mcg tablet (Levoxyl) 1 tab by mouth every day - 30 minutes prior to meal - for hypothyroidism." Concurrent review of the client's September 2011 Medication Administration Record (MAR) revealed that the designated time for taking the Levothyroxine was 7 a.m.</p> <p>The registered nurse (RN) was interviewed two days later, on 9/22/2011, beginning at 11:48 a.m. She stated that a trained medication employee (TME) typically administered Client #3's Levothyroxine prior to breakfast. When informed that the LPN had administered the client's Levothyroxine along with her other medications, immediately prior to eating breakfast, she agreed to review the client's MAR. At 12:01 p.m., the RN confirmed that the morning LPN had placed her initials on the MAR on 9/19/2011, 9/20/2011 and 9/21/2011. A TME had initialed the MAR on 9/22/2011. The RN stated that Levothyroxine should be taken on an empty stomach to ensure absorption.</p> <p>The facility failed to ensure that Client #3's Levothyroxine was administered 30 minutes prior to her meal, in accordance with her POS.</p>	W 368	<p>W368</p> <p>Delegating RN will provide additional training to LPN and TME in correct medication administration in accordance with the physician order for client #3. Periodic medication pass observation will be conducted by the delegating RN to ensure compliance and provide technical assistance. The RN has consulted with the primary care physician regarding medication for client #3 and administration time of the medication has been changed to ensure accuracy.</p> <p>The Delegating RN will observe medication administration periodically to ensure that all medications are administered in accordance with clients' physician orders and medication administration protocols. Follow up action as necessary and applicable will ensue for LPN's TME who fail to adhere to medication administration protocols. Additionally, The Delegating RN will provide refresher training to TME's and LPN on clients' physician orders by 10/30/11.</p>	<p>9/23/11 & 10/11/11 Ongoing</p> <p>9.22.11 Ongoing</p>

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W 368	Continued From page 3 This is a repeat deficiency. See Federal Deficiency Report, dated 9/16/2010 - Citation W368	W 368			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered without error, for one of the four clients residing in the facility. [Client #3] The finding includes: [Cross-refer to W368] On 9/20/2011, at 7:50 a.m., the morning medication nurse (a licensed practical nurse, LPN) administered Client #3's medications. At 7:52 a.m., the client went to the dining room and began eating her breakfast. On 9/20/2011, at 4:56 p.m., review of Client #3's physician's order sheets (POS) dated September 2011, revealed the physician ordered "Levothyroxine Sodium 125 mcg tablet (Levoxyf) 1 tab by mouth every day - 30 minutes prior to meal - for hypothyroidism." Concurrent review of the client's September 2011 Medication Administration Record (MAR) revealed that the designated time for taking the Levothyroxine was 7 a.m. The registered nurse (RN) was interviewed two days later, on 9/22/2011. At 12:01 p.m., she stated that Levothyroxine should be taken on an empty stomach to ensure absorption. She further	W 369	Cross reference response to W 368.		

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W 369	Continued From page 4 acknowledged that this was a (timing) medication error. This is a repeat deficiency. See Federal Deficiency Report, dated 9/16/2010 - Citation W389	W 369		
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, staff interview and record review, the facility failed to ensure clients' adaptive equipment were available and in good repair to ensure their health and safety, for one of the two sampled clients. [Client #2] The finding includes: Observation and interview with the facility's qualified intellectual disabilities professional (QIDP) on 9/20/2011, at approximately 10:25 a.m., revealed the grab bar in the bathroom in the main hallway was broken and was falling off the wall in the shower. The grab bar was not functional and was in no structural condition to provide any physical support. Record review on 9/21/2011, at 11:20 a.m., revealed Client #2's Occupational Therapy Update, dated 2/28/2011, recommended that the facility ensure the "continued use of (the) grab bar on the tub and	W 436	W436 The Grab Bars were replaced on 9/22/2011. The QIDP/Program Manager will monitor the residence weekly using the environmental compliance form as the method of QA. Follow up action will occur as applicable for any needs noted as a result of the environmental audit. Documentation of the environmental audits will be maintained in the Program Manger's environmental audit book along with any follow up that has occurred.	9.22.11 Ongoing

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W 436	Continued From page 5 toilet for safety." Interview with the QIDP on 9/21/2011, at approximately 11:30 a.m., confirmed the grab bar was broken and that it provided little to no support.	W 436	See responses to W 436 on page 5 of 6.
(X5) COMPLETION DATE			

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1000 INITIAL COMMENTS

A licensure survey was conducted from 9/20/2011 through 9/22/2011. A random sampling of two residents was selected from a population of four women with varying degrees of intellectual and developmental disabilities.

The findings of this survey were based on observations at the group home and two day programs, interview with individuals, direct support staff and management, and a review of the habilitation and administrative records including unusual incident reports.

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

1090 3504.1 HOUSEKEEPING

The interior and exterior of each GHPID 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 staff interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the environmental upkeep of the facility to maintain the health and safety of four of four persons residing in the facility. [Residents #1, #2, #3 and #4]

The findings include:

1. The toilet seat and supportive chair rails in the hall bath (Bath #1) were extremely loose and

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See responses to 1190 on page 2 of 8.

Health Regulation & Licensing Administration

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

STATE FORM

Rochelle Odejobi
TITLE

DATE
10/12/2011

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I 090	Continued From page 1 could be moved from side to side. 2. The supportive grab bar on the wall in the shower in Bath #1 was broken (extremely loose) and coming off the wall. [Reference Federal Deficiency Citation W436] 3. The floor in Resident #3's bedroom was extremely warped and bowed to the point that the closet door (hot water heater closet) was very difficult to push shut or open. Further observation revealed the walls and floor around the base of the hot water heater appeared covered in either mold or mildew. Interview with the qualified intellectual disabilities professional on 8/20/2011, at approximately 10:30 a.m., confirmed that the floor was bowed due to the hot water heater leaking and that repair of the wall and floor had been pending for some time. 4. The weather stripping along the base of the exit door in Resident #3's bedroom was torn and coming off the door. 5. Paint on the two shutters to either side of the front door was peeling and/or chipped. 6. The lower half of the front storm door had numerous knicks, dents and/or markings that presented an eyesore.	I 090	1090 1. The QIDP/Program Manager will have repaired/replaced the toilet seat and supportive chair rails in the hall bath (Bath#1). 2. The QIDP/Program Manager has had the supportive grab bar on the wall in the shower in Bath #1 repaired 3. The QIDP/Program Manager will have repaired/replaced the floor in Resident #3 bedroom as well as the removal and sanitation of the substance (mold or mildew) on the walls and floor around the hot water heater. 4. The QIDP/Program Manager will have repaired/replaced the weather stripping along the base of the exit door in Resident #2 bedroom removed, repaired or replaced. 5. The QIDP/Program Manager will have the two shutters on either side of the front door painted. 6. The QIDP/Program Manager will repair/replace the lower half of the front door that had knicks, dents and/or markings.	10/14/2011 Ongoing 9-22-11 Ongoing 10.15.11 Ongoing 10.15.11 10.15.11 10.15.11 10.15.11 10.15.11 Ongoing
I 180	3508.1 ADMINISTRATIVE SUPPORT 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	I 180	On an ongoing basis, the QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repairing as necessary	10.15.11 Ongoing

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1180	<p>Continued From page 2</p> <p>review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the residents' needs, for one of the two sampled residents: [Resident #2]</p> <p>The finding includes:</p> <p>The QIDP failed to coordinate Resident #2's PT services to ensure the development and implementation of a range of motion program, as follows:</p> <p>Observation on 9/20/2011, beginning at 1:00 p.m., revealed Resident #2 walked slowly and was very unsteady at times as she moved around her environment. Review of Resident #2's medical records on 9/21/2011, at 10:27 a.m., revealed her 4/8/2010 Physical Therapy Evaluation assessed her "decreased range of motion of the ankles and weakness are related to an increase in risk for fall." Further review of the PT assessment revealed the recommendation that the facility "Set up an exercise and range of motion program to address ankle range of motion and general decreased strength (therapist to set up and in-service staff)."</p> <p>Interview with the QIDP on 9/21/2011, at 1:05 p.m., revealed the PT had yet to set-up the range of motion program for Resident #2's ankle. Further record review confirmed there was no evidence that the range of motion program for Resident #2's ankle had been put in place.</p>	1180	<p>1180</p> <p>The QIDP in conjunction with the delegating RN has scheduled client # 2 for a physical therapy re-evaluation at [redacted]. Upon receipt of the assessment based on client #2 current PT needs, recommendations will be implemented and all staff will be trained on recommendations from PT.</p> <p>Periodic observation will be done by program manager/QIDP to ensure compliance and provide technical assistance as needed. In cases when staff failed to carry out recommendations, staff will be retrained and corrective action may be taken.</p>	<p>10-31-11 Ongoing</p> <p>9/23/11 & 10/11/11 Ongoing</p>
1206	3509.6 PERSONNEL POLICIES	1206		
	Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been			

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1206	Continued From page 3 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 interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for 2 of the 12 employees and 1 of the 8 consultants. [program manager, registered nurse and pharmacist] The findings include: On 9/20/2011, beginning at 3:00 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for the following: - program manager; - registered nurse; and, - pharmacist. On 9/21/2011, at 4:21 p.m., the qualified intellectual disabilities professional and the program manager acknowledged that there was no evidence of a health inventories performed by a physician for the aforementioned personnel. They stated they would seek additional information from their corporate office. No additional information was presented before the survey ended the following day.	1206	1206 The outstanding health certificates for the program manger, registered nurse and pharmacist have been secured and placed on file in their health records in the administrative office. QIDP/Personnel Administrator will ensure that all employees and health care professional have current health certificates including Program Manager, registered Nurse and proper documentation on Pharmacist. Personnel Administrator will perform quarterly monitoring to ensure compliance and adequate notification to employees of upcoming expiration dates. Employees who are not compliance with having their health certifications completed annually per protocols and regulations will be removed from the schedule until such time that their health certifications have been completed/received by Human Resources.	9/28/2011- Ongoing
1227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following:	1227		

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I 227	Continued From page 4 (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to show evidence that all employees had current training to implement emergency measures, for 3 of the 8 direct support staff and 1 of the 2 nurses employed. (S1, S2, S3 and N2) The findings include: On 9/20/2011, beginning at 3:00 p.m., review of the personnel records failed to show evidence that S1, S2, S3 and N2 had received current Cardiopulmonary Resuscitation (CPR) certification. On 9/21/2011, at 4:21 p.m., the qualified intellectual disabilities professional and the program manager acknowledged that there was no evidence of current CPR certifications for S1 and S3. They thought they could secure evidence that S2 and N2 had received updated CPR certification; however, no additional information was presented before the survey ended the following day.	I 227	I 227 The CPR Certifications for S2 and S3 have been placed on file in their training records. S1 and N1 completed CPR training on 9/28/2011. Sign in sheet indicating their participation in and successful completion of the training has been placed on file in their training records. Professional Development Coordinator/Director of Programs will perform quarterly training record audits of all employee training records to ensure compliance. Notification to employees of expiring certifications will be issued 60 days prior to expiration along with a schedule of upcoming classes in which the employees will be registered. Employees who fail to renew their CPR certifications prior to their expiration will be removed from the schedule until such time that their CPR certifications are current and received by the training department.	9/28/2011- Ongoing	
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	I 379			

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1379	<p>Continued From page 5</p> <p>interfere 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.</p> <p>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 ensure that all incidents that present a risk to residents' health and well-being were reported immediately and in writing to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the four residents of the GHPID. (Resident #1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 9/20/2011, at approximately 10:15 a.m., review of facility incident reports revealed that on 12/4/2010, staff documented that Resident #1 fell while ambulating in the driveway. According to the incident report and corresponding investigation report, dated 1/7/2011, the resident was taken to a hospital emergency room (ER) where she was assessed and diagnosed with "abrasion face, contusion face and fracture nasal bones, closed." Pre and post-survey reviews of incidents that were reported to DOH/HRLA revealed no evidence that the GHPID sent written notification of Resident #1's fall and ER visit on 12/4/2010. On 9/20/2011, at 8:30 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that on 8/24/2010, day program staff documented that Resident #1 sustained a 	1379	<p>1379</p> <p>1-2. QIDP/Director of Programs and Incident Management Coordinator will ensure staff are retrained on the incident management reporting procedures and protocol for incidents at home and at the day program.</p> <p>Director of Programs/Incident Management Coordinator will revise internal policies for reporting incidents to reflect the Residential Provider's responsibility to report all incidents to the DOH per regulatory guidelines. Incident Management Coordinator will in-service all staff on the revised incident management procedures and notifications.</p> <p>In the event that policies for incident reporting are not followed, corrective action as appropriate will ensue.</p>	<p>10-15-11 Ongoing</p> <p>10-15-11 Ongoing</p> <p>10/15/2011 Ongoing</p>

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I 379	Continued From page 6 "laceration" to her face when she fell while ambulating at her day program. This was confirmed on 8/21/2011, at approximately 11:45 a.m., through interview with the day program's nurse and activities coordinator and review of the nurse's progress notes. Resident #1 was taken to a hospital ER via ambulance from the day program. Pre and post-survey reviews of incidents that were reported to DOH/HRLA revealed no evidence that the GHPID sent written notification of Resident #1's fall and ER visit on 8/24/2011. When interviewed on 9/21/2011, beginning at 1:50 p.m., the facility's program manager and the QIDP acknowledged that the GHPID had not submitted a written incident report.	I 379	See responses to I 379 on page 8 of 8.
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview and record verification, the group home for persons with intellectual disabilities (GHPID) failed to report any irregularities to the primary care physician (PCP), for one of the four residents of the GHPID. (Resident #3) The findings include: On 9/20/2011, at 7:44 a.m., Resident #3 was observed walking from her bedroom to the nurse's desk in the office. At 7:50 a.m., the morning medication nurse (a licensed practical nurse, LPN) administered Resident #3's medications. At 7:52 a.m., the resident went to the dining room and began eating her breakfast.	I 473	See responses to I 473 on page 8 of 8.

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1473	<p>Continued From page 7</p> <p>She was observed to finish her meal at 8:10 a.m.</p> <p>On 9/20/2011, at 4:58 p.m., review of Resident #3's physician's order sheets (POS) dated September 2011, revealed the physician ordered "Levothyroxine Sodium 125 mcg tablet (Levoxy) 1 tab by mouth every day - 30 minutes prior to meal - for hypothyroidism." Concurrent review of the resident's September 2011 Medication Administration Record (MAR) revealed that the designated time for taking the Levothyroxine was 7 a.m.</p> <p>The registered nurse (RN) was interviewed two days later, on 9/22/2011, beginning at 11:46 a.m. She stated that a trained medication employee (TME) typically administered Resident #3's Levothyroxine prior to breakfast. When informed that the LPN had administered the resident's Levothyroxine along with her other medications, immediately prior to eating breakfast, she agreed to review the resident's MAR. At 12:01 p.m., the RN confirmed that the morning LPN had placed her initials on the MAR on 9/19/2011, 9/20/2011 and 9/21/2011. A TME had initialed the MAR on 9/22/2011. The RN stated that Levothyroxine should be taken on an empty stomach to ensure absorption.</p> <p>The facility failed to ensure that Resident #3's Levothyroxine was administered 30 minutes prior to her meal, in accordance with her POS.</p> <p>There was no evidence the PCP was made aware of any medication irregularities.</p> <p>This is a repeat deficiency. See Licensure Deficiency Report, dated 9/16/2010 - Citation 1401</p>	1473	<p>1473</p> <p>Delegating RN will provide additional training to LPN and TME in correct medication administration in accordance with the physician order for client #3. Periodic medication pass observation will be conducted by the delegating RN to ensure compliance and provide technical assistance. The RN has consulted with the primary care physician regarding medication for client #3 and administration time of the medication has been changed to ensure accuracy.</p> <p>The Delegating RN will observe medication administration periodically to ensure that all medications are administered in accordance with clients' physician orders and medication administration protocols. Follow up action as necessary and applicable will ensue for LPN's TME who fail to adhere to medication administration protocols. Additionally, The Delegating RN will provide refresher training to TME's and LPN on clients' physician orders by 10/30/11.</p> <p>9/23/11 & 10/11/11 Ongoing</p> <p>9.22.11 Ongoing</p>

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R 000	INITIAL COMMENTS A licensure survey was conducted from 9/20/2011 through 9/22/2011. A random sampling of two residents was selected from a population of four women with varying degrees of intellectual and developmental disabilities. The findings of this survey were based on observations at the group home and two day programs, interview with individuals, direct support staff and management, and a review of the habilitation and administrative records including unusual incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	R 000			
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 8 direct support staff. [S1] The finding includes: On 9/20/2011, at approximately 3:10 p.m., review	R 125	See response to R 125 on page 2 of 2.		

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

STATE FORM

6889

95UY11

TITLE

(X6) DATE

10/12/2011

If continuation sheet 1 of 2

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R-125	Continued From page 1 of the personnel record for S1 revealed that a Maryland background check had been documented on 3/30/2010. However, her employment application form indicated that she had been employed in the District of Columbia from 11/2009 - 1/2009. There was no evidence that a background check had been obtained in the District of Columbia. On 8/21/2011, at 1:45 p.m., the qualified intellectual disabilities professional confirmed the finding and further indicated that she would bring it to the attention of their administrator. No additional information was presented before the survey ended the following day at 1:00 p.m.	R 125	R 125 The Criminal Background Check for staff A.H. for Washington DC was completed on 8/28/2011. QIDP/Personnel Administrator will ensure that all employees' criminal background checks all completed for all jurisdictions in which the employees had worked or resided within the 7 year prior to the check for new and current employees.	9/28/2011- Ongoing