

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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2014
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NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET, NE WASHINGTON, DC 20019
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from January 27, 2014 through January 29, 2014. A sample of three clients was selected from a population of five men and women with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Behavior Support Plan - BSP Director of Nursing - DON Group Home for Individuals with Intellectual Disabilities - GHIID Facility Manager (aka House Manager) - FM Human Rights Committee - HRC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Milligrams - mg Milliliter - ml Physician Order Sheets - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN</p>	W 000	<p><i>Received 2/21/14 DWH</i></p>	
W 262	<p><b>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</b></p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that,</p>	W 262		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Cretia R. Moore* Director of Residential Services 2/21/14

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.

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W 262	<p>Continued From page 1 in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to show evidence that all BSPs that incorporate restrictive measures had been reviewed and/or approved by the specially constituted committee (i.e. Human Rights Committee), for the one client with a restrictive plan (of five clients) residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On January 27, 2014, at approximately 9:20 a.m., the FM (FM #1) stated that Client #4 was the sole individual who had a restrictive plan. The client's BSP included the use of psychotropic medications. At 9:37 a.m., FM #1 stated that she would make available for review the minutes of the facility's HRC meetings from the past 12 months.</p> <p>On January 28, 2014, at 9:50 a.m., review of Client #4's current POS (January 2014) confirmed that the client received psychotropic medications. The POS and the client's monthly psychotropic medication review forms reflected the daily administration of Prozac 60 mg and Revia 50 mg. Continued review of Client #4's record revealed no evidence that the HRC had reviewed and approved the client's BSP.</p> <p>On January 28, 2014, at 12:00 p.m., the substitute QIDP (QIDP #1) who was assigned to provide coverage while the longtime QIDP</p>	W 262	<p>W262 The HRC team meeting in which the psychotropic drug regimen of Client #4 was discussed occurred on 7-23-13. A review of the minutes reveals that it is not clearly documented that the team discussed the psychotropic drug regimen or approved it. The Committee will revisit the issue for Client #4 in the meeting to be held...2-25-14 The QDDP will ensure that both the agenda and the minutes reflect discussion of the concern and the team's decision (about the regimen)...3-1-14 Additionally, the Director of Residential Programs will ensure that the meeting process is revised to ensure: The HRC Chairperson contacts each QDDP that will have individuals supported discussed at the scheduled meeting to obtain the exact issues that must be reviewed person-by-person; The HRC Chairperson will then ensure that the agendas for the meetings reflect location-specific and person-specific issues that will be discussed including all that require approval votes by the committee members; It will be the responsibility of each QDDP to capture the feedback of the committee and provide cluster-specific minutes to the HRC Chairperson that reflect the Committee's feedback and decisions on each person and topic discussed; The HRC Chairperson will collect the cluster-specific minutes within 48 hours of the meeting date and review them for accuracy; The HRC Chairperson is responsible for ensuring that general considerations discussed (i.e. not involving a specific person or cluster but rather the entire company and census) are captured in the minutes. Minutes are submitted to the Director of Residential Services within 5 working days of the meeting date for review and final approval and then filed both in the home records and at the Main Office. The Director of Residential Services will maintain a comprehensive file for the meeting minutes and agendas.</p>		

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W 262	Continued From page 2 (QIDP #2) was in hospital, agreed to the second request for HRC minutes and documentation. No additional information was made available for review before the survey ended the next day at 3:22 p.m.	W 262			
W 263	At the time of the survey, there was no evidence that the facility's HRC had reviewed and approved Client #4's BSP that incorporated the use of Prozac and Revia. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (HRC) failed to ensure that restrictive programs were used only with written consent, for the one client with a restrictive plan (of five clients) residing in the facility. (Client #4)  The finding includes:  On January 27, 2014, at approximately 9:20 a.m., FM #1 stated that Client #4 had a restrictive plan. The client's BSP included the use of psychotropic medications.  On January 28, 2014, beginning at 9:50 a.m., review of Client #4's current POS (January 2014) confirmed that the client received Prozac 60 mg and Revia 50 mg daily. Continued review of	W 263	W263  The mother of Client #4 had reviewed both the psychotropic drug regimen and BSP once again with the QDDP and had signed updated consents on 7-6-13. These consents were removed from the record by the QDDP in order to send copies to the service coordinator of DDS (1-24-14). Because the fax machine at 57 <sup>th</sup> was not working at the time, the QDDP took the documents to a nearby home and faxed them to the service coordinator. Immediately thereafter, the QDDP went out sick with the documents in her possession. The documents have been placed back in the record and copies are attached...2-21-14  In the future, the QDDP will ensure that any document removed from the records for any reason are placed back in the record within 24 hours...2-214		

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W 263	Continued From page 3 Client #4's record revealed that on June 20, 2012, the client's substituted health care decision-maker (the client's mother) had granted written consent for use of the medications for a 12-month period. The consent form reflected a June 20, 2013 expiration date. There was no evidence that renewed consent had been sought since the previous consent had expired seven months earlier.  On January 29, 2014, at 2:21 p.m., interview with QIDP #1 revealed that she and RN #1 had taken consent forms to Client #4's mother on the day before (January 28, 2014). She presented forms that reflected the mother's consent for the BSP and the continued use of Prozac and Revia.  At the time of the survey, there was no evidence that the HRC monitored the expiration dates on consents, to ensure that the facility obtained written consent from Client #4's mother for the continued use of restrictive behavior management techniques, including the use of Prozac and Revia.	W 263			
W 331	<b>483.460(c) NURSING SERVICES</b>  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure that clients received medications only with a written order from the physician, and nursing staff failed to seek clarification of administration times when indicated, to ensure compliance with each client's POS, for one of	W 331			

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W 331	<p>Continued From page 4 five clients residing in the facility . (Client #4)</p> <p>The findings include:</p> <p>I. The facility's nursing services failed to obtain a written order from the PCP before administering a Cranberry supplement, as follows:</p> <p>On January 27, 2014, at 6:58 p.m., Client #4 was observed being administered 1 tablet of Cranberry supplement with Probiotic and Vitamin C, along with other medications.</p> <p>On January 28, 2014, at approximately 10:18 a.m., review of Client #4's MARs revealed nurses had documented administering the Cranberry supplement once daily at 6:00 p.m. beginning on January 10, 2014. Review of Client #4's POS, however, failed to show evidence of an order from the PCP.</p> <p>On January 28, 2014, at 1:26 p.m., the RN reviewed Client #4's MARs and POS and confirmed the aforementioned findings . The RN stated she would look for the original order for Cranberry supplement. Follow-up interview with the RN on January 29, 2014, at 2:28 p.m., revealed that the PCP wrote an order for the Cranberry supplement on the previous day (January 28, 2014). There was no explanation offered regarding the failure to obtain a signed , written order from the PCP in the 13 days since the supplement was added to the client's medication regimen.</p> <p>II. The facility's nursing services failed to seek clarification of the desired administration time for two of Client #4's medications, as follows:</p>	W 331	<p>W331</p> <p>The Primary Care Physician instructed the RN to begin the Cranberry supplement for Client #4. The PCP was faxed the verbal order to sign on 1-7-14 and signed it on...1-8-14. However, the signed order was not recovered from the PCP and placed in the record by the survey date. The signed order has been obtained and is in the record (copy attached)...2-21-14</p> <p>The RN will ensure that verbal orders are placed in the individual record no more than 24 hours after obtaining the PCP's signature. The QDDP will monitor compliance via routine record audits conducted at minimum monthly...3-1-14</p>		

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W 331	<p>Continued From page 5</p> <p>On January 27, 2014, at 6:58 p.m., Client #4 was observed being administered 3 tablets (150 mg) of Dilantin and 2 tablets (17.2 mg) of Senna stool softener, along with other medications.</p> <p>On January 28, 2014, at approximately 10:18 a.m., review of Client #4's POS revealed a telephone order for 150 mg chewable Dilantin, dated June 19, 2013, "at night... for seizures." The order had been signed by the PCP on June 20, 2013. In the months since June 2013, Client #4's POS prepared by the pharmacist said to administer the Dilantin "at bedtime." The POS also said the Senna stool softener should be administered "at bedtime." By contrast, most of the orders for other medications observed being administered were to be administered in the "evening" or "daily." Client #4's MARs reflected a 6:00 p.m. designated administration time for the Dilantin, Senna and all other medications observed that evening.</p> <p>On January 28, 2014, at 1:30 p.m., the RN reviewed Client #4's MARs and POS and confirmed the aforementioned findings. The RN stated she would seek clarification from the PCP regarding the prescribed administration time of both medications. On January 29, 2014, at 2:30 p.m., the RN said she had reviewed the client's medication regimen with the PCP. The PCP had instructed the facility to administer Client #4's Dilantin at 8:00 p.m. and the Senna was to be given with the other medications at 6:00 p.m.</p> <p>At the time of the survey, there was no evidence that the supervisory RN had reviewed the designated medication administration times, and</p>	W 331	<p>II</p> <p>The RN has discussed the issue with the PCP to ensure that the Physician's Orders and the MARs reflect the same regimen exactly for Client #4. The Physician's Orders have been modified to reflect specific times for the two medications as opposed to referencing "bed time" and the Physician's Orders and MARs now match exactly for these medications...2-21-14</p> <p>The RN and PCP will meet on a routine quarterly basis to review the physician's orders and the MARs to ensure that they are accurate and consistent with each other...3-1-14</p> <p>The RN will review the orders and MARs monthly...3-1-14</p>		

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W 331	Continued From page 6	W 331			
W 369	clarified orders when indicated, to ensure compliance with physician's orders.  <b>483.460(k)(2) DRUG ADMINISTRATION</b>  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, interview and record review, the facility failed to ensure that each client's prescribed drugs, including stool softeners, were administered without error, for one of five clients residing in the facility. (Client #1)  The finding includes:  On January 27, 2014, at 7:43 p.m., LPN #1 was observed administering Client #1's medications, including 45 ml of Constulose.  On January 28, 2014, at 10:50 a.m., review of Client #1's MARs and POS for January 2014 revealed that the client should have received 50 ml. After being informed at 1:30 p.m., that Client #1 was observed being administered 45 ml instead of 50 ml of Constulose, the RN reviewed the client's POS and confirmed that the order had been changed from 45 ml to 50 ml. The change to 50 ml (effective January 10, 2014) was reflected on the MAR as well. The RN stated that she would address the issue with LPN #1.  Observations during the evening medication administration on January 27, 2014 revealed Client #1 did not receive all medications without	W 369	W369  The LPN when interviewed by the RN concerning this medication pass indicated that she did indeed pour and administer 50 ml of Constulose to Client #4. MTS is proceeding on the assumption that the surveyor observation is accurate. The RN will provide training with the LPN and conduct observations of medication passes to ensure that the liquid medication is properly measured and administered consistent with the regimen prescribed...2-27-14		

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W 369	Continued From page 7 error.	W 369			
W 393	483.460(n)(1) LABORATORY SERVICES  If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for the one individual (out of five clients that reside in the facility) whose blood glucose was being tested by facility staff. (Client #3)  The finding includes:  On January 28, 2014, at 9:15 a.m., review of Client #3's POS and MARs revealed that beginning on October 24, 2013, the client had been receiving weekly finger sticks to test blood sugar levels. When asked whether the facility had a current Clinical Laboratory Improvement Act (CLIA) certificate of waiver, the RN stated she thought yes; however she would check with their DON. Follow-up interview with the RN on January 29, 2014, at 2:26 p.m., revealed that the DON was completing forms and they will submit an application to obtain a certificate of waiver.  At the time of the survey, the facility failed to obtain a CLIA certificate prior to conducting laboratory testing.	W 393	W393  The CLIA certificate has been applied for and will be obtained by...2-27-14 MTS will ensure that certificates are obtained where needed with effective tracking conducted by the DON...3-1-14		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS  The facility must provide each client with a clean,	W 418			

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W 418	<p>Continued From page 8 comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a comfortable mattress, for three of five clients residing in the facility. (Clients #2, #3 and #5)</p> <p>The findings include:</p> <p>I. On January 29, 2014, at 1:33 p.m., the center area of the mattress used by Client #2 was concave and sunken, in relation to the rest of his mattress. The client was not in bed at the time. Upon closer examination, the mattress springs were palpable through the padding in the center part of the mattress.</p> <p>II. On January 29, 2014, at 1:35 p.m., the center area of the mattress used by Client #5 was concave and sunken, in relation to the rest of his mattress. The client was not in bed at the time. Upon closer examination, the mattress springs were palpable through the padding in the center part of the mattress.</p> <p>III. On January 29, 2014, at 1:45 p.m., the center area of the mattress used by Client #3 was concave and sunken, in relation to the rest of his mattress. The client was not in bed at the time. Upon closer examination, the mattress springs were palpable through the padding in the center part of the mattress.</p> <p>The FM #1, who was present at the time, concurred that the mattress springs no longer provided support. FM #1 then stated the intention</p>	W 418	<p>W418</p> <p>MTS has been following up on this concern for some time because the historical vendor used went out of business and a new vendor for such durable medical equipment that carried the needed hospital beds was difficult to find. City Care has been identified and the beds have been ordered. They should be obtained by...3-15-14</p>		

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W 418	Continued From page 9 to acquire new mattresses for the three aforementioned clients.	W 418			

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**Health Regulation & Licensing Administration**

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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from January 27, 2014 through January 29, 2014. A sample of three residents was selected from a population of five men and women with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Behavior Support Plan - BSP                  Director of Nursing - DON                  Group Home for Individuals with Intellectual Disabilities - GHIID                  Facility Manager (aka House Manager) - FM                  Human Rights Committee - HRC                  Individual Support Plan - ISP                  Intermediate Care Facility - ICF                  Licensed Practical Nurse - LPN                  Medication Administration Record - MAR                  Milligrams - mg                  Milliliter - ml                  Physician Order Sheets - POS                  Qualified Intellectual Disabilities Professional - QIDP                  Registered Nurse - RN</p>	1 000		
1 071	<p><b>3503.2 BEDROOMS AND BATHROOMS</b></p> <p>Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator.</p> <p>This Statute is not met as evidenced by:</p>	1 071		

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

TITLE

(X6) DATE

*Antette B. Murre*, Director of Residential Services, 2/20/14

STATE FORM

6899

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If continuation sheet 1 of 8

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NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 1/2 57TH STREET, NE WASHINGTON, DC 20019</b>
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I 071	<p>Continued From page 1</p> <p>Based on observation and interview, the GHIID failed to ensure a distance of at least three feet between resident beds was maintained, for two of five residents in the facility . (Residents #2 and #5)</p> <p>The finding includes:</p> <p>Observation on January 29, 2014, at 1:32 p.m., revealed the space between Residents #2 and #5's hospital beds was less than the required three feet (36 inches). The two beds were placed alongside each other, lengthwise, with a space of only 2 inches between them. The facility manager (FM #1), who was present at the time, stated that this issue had been identified approximately three weeks before the survey when the facility was inspected by an outside entity.</p> <p>At the time of the survey, there was no evidence that each client's bed in the facility was placed at least three feet from any other bed, as required.</p>	I 071	<p>3503.2</p> <p>The beds have been moved with a dresser placed in between so that the proper distance apart has been achieved. The Home and Vehicle Maintenance Coordinator has inspected and measured to ensure compliance...2-8-14</p>	
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all employees and health</p>	I 206		

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I 206	Continued From page 2  care professionals had current health certificates on file, for 1 of 12 non-licensed employees. (FM #1)  The finding includes:  On January 27, 2014, at 9:37 a.m., FM #1 stated that she would make available for review the personnel records for all employees and consultants working in the facility.  On January 28, 2014, beginning at 4:00 p.m., review of personnel records in the facility revealed no evidence of a physician's health inventory/ certificate for FM #1. According to her file, FM #1 had been employed since 1999.  Continued review of personnel records on January 29, 2014, beginning at 12:36 p.m. revealed no evidence of a current health certificate for FM #1. At 2:31 p.m., QIDP #1 presented additional personnel records; however, FM #1's health certificate was not among them. No additional information was made available for review before the survey ended that afternoon at 3:22 p.m.  At the time of the survey, the facility failed to show evidence that all employees obtained a physician's certification of health status prior to employment and annually thereafter.	I 206	3509.6  A copy of the current health certificate for FM is attached...2-21-14 HR maintains tracking and auditing systems to ensure routine compliance...2-21-14	
I 271	3513.1(b) ADMINISTRATIVE RECORDS  Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:  (b) Personnel records for all staff including job	I 271		

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1271	<p>Continued From page 3</p> <p>descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHID failed to make available for inspection personnel records for each employee, for none (0) of the 6 LPNs. (LPNs #1, #2, #3, #4, #5, #6 and #7)</p> <p>The findings include:</p> <p>On January 27, 2014, at 6:45 a.m., LPN #1 was observed working in the nurse's office in the facility. LPN #2 was observed moments later putting materials away after having administered medications to the residents. Later that morning, at 8:00 a.m., LPN #3 was observed working directly with Resident #3. LPN #3 stated that she was filling in for LPN #6 who was away on vacation. Also on January 27, 2014, at 6:00 p.m., LPN #4 was observed administering Resident #3's medications and at 7:07 p.m., LPN #5 was observed administering medications to Residents #1 and #5.</p> <p>On January 27, 2014, at 9:37 a.m., FM #1 stated that she would make available for review the personnel records for all employees and consultants working in the facility.</p> <p>Personnel records were reviewed in the GHID on January 28, 2014, beginning at 4:00 p.m. There were no files available for any of the LPNs. Continued review of personnel records on January 29, 2014, beginning at 12:36 p.m. revealed no evidence of files being maintained for LPNs. At 2:31 p.m., QIDP #1 presented additional personnel records; however, nurses' files were not among them. No additional</p>	1271	<p>3513.1(b)</p> <p>MTS maintains personnel file records that travel from the main office to the specified home during surveys. These files include the LPN files. For reasons not adequately explained, the files did not make it to the home for the surveyor to review. The Director of Residential Services has reinforced the process with the relevant management staff and the QDDPs...2-10-14 Copies of the relevant LPN files are attached...2-21-14</p>	

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I 271	Continued From page 4 information was made available for review before the survey ended that afternoon at 3:22 p.m.	I 271		
I 500	<p><b>3523.1 RESIDENT'S RIGHTS</b></p> <p>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.</p> <p>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 five residents of the facility. (Residents #1 and #4)</p> <p>The findings include:</p> <p>i. [483.460(k)(2)] The GHIID failed to ensure Residents #1's and #4's right to receive medications in accordance with physician's orders, as follows:</p> <p>A. The facility's nursing services failed to ensure that Resident #1 received Constulose stool softener at the dosage prescribed by the PCP, as follows:</p> <p>On January 27, 2014, at 7:43 p.m., LPN #1 was observed administering Resident #1's medications, including 45 ml of Constulose.</p>	I 500	<p>3523.1</p> <p>The LPN when interviewed by the RN concerning this medication pass indicated that she did indeed pour and administer 50 ml of Constulose to Client #4. MTS is proceeding on the assumption that the surveyor observation is accurate. The RN will provide training with the LPN and conduct observations of medication passes to ensure that the liquid medication is properly measured and administered consistent with the regimen prescribed...2-27-14</p> <p>The RN has discussed the issue with the PCP to ensure that the Physician's Orders and the MARs reflect the same regimen exactly for Client #4. The Physician's Orders have been modified to reflect specific times for the two medications as opposed to referencing "bed time" and the Physician's Orders and MARs now match exactly for these medications...2-21-14</p>	

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I 500	<p>Continued From page 5</p> <p>On January 28, 2014, at 10:50 a.m., review of Resident #1's MARs and POS for January 2014 revealed that the resident should have received 50 ml. After being informed at 1:30 p.m., that Resident #1 was observed being administered 45 ml instead of 50 ml of Constulose, the RN reviewed the resident's POS and confirmed that the order had been changed from 45 ml to 50 ml. The change to 50 ml (effective January 10, 2014) was reflected on the MAR as well. The RN stated that she would address the issue with LPN #1.</p> <p>B. The facility's nursing services failed to seek clarification of the desired administration time for two of Resident #4's medications, as follows:</p> <p>On January 27, 2014, at 6:58 p.m., Resident #4 was observed being administered 3 tablets (150 mg) of Dilantin and 2 tablets (17.2 mg) of Senna stool softener, along with other medications.</p> <p>On January 28, 2014, at approximately 10:18 a.m., review of Resident #4's POS revealed a telephone order for 150 mg chewable Dilantin, dated June 19, 2013, "at night... for seizures." The order had been signed by the PCP on June 20, 2013. In the months since June 2013, Resident #4's POS prepared by the pharmacist said to administer the Dilantin "at bedtime." The POS also said the Senna stool softener should be administered "at bedtime." By contrast, most of the orders for other medications observed being administered were to be administered in the "evening" or "daily." Resident #4's MARs reflected a 6:00 p.m. designated administration time for the Dilantin, Senna and all other medications observed that evening.</p>	I 500	<p>The RN and PCP will meet on a routine quarterly basis to review the physician's orders and the MARs to ensure that they are accurate and consistent with each other...3-1-14 The RN will review the orders and MARs monthly...3-1-14</p> <p>The HRC team meeting in which the psychotropic drug regimen of Client #4 was discussed occurred on 7-23-13. A review of the minutes reveals that it is not clearly documented that the team discussed the psychotropic drug regimen or approved it. The Committee will revisit the issue for Client #4 in the meeting to be held...2-25-14 The QDDP will ensure that both the agenda and the minutes reflect discussion of the concern and the team's decision (about the regimen)...3-1-14 Additionally, the Director of Residential Programs will ensure that the meeting process is revised to ensure: The HRC Chairperson contacts each QDDP that will have individuals supported discussed at the scheduled meeting to obtain the exact issues that must be reviewed person-by-person; The HRC Chairperson will then ensure that the agendas for the meetings reflect location-specific and person-specific issues that will be discussed including all that require approval votes by the committee members; It will be the responsibility of each QDDP to capture the feedback of the committee and provide cluster-specific minutes to the HRC Chairperson that reflect the Committee's feedback and decisions on each person and topic discussed; The HRC Chairperson will collect the cluster-specific minutes within 48 hours of the meeting date and review them for accuracy; The HRC Chairperson is responsible for ensuring that general considerations discussed (i.e. not involving a specific person or cluster but rather the entire company and census) are captured in the minutes. Minutes are submitted to the Director of Residential Services within 5 working days of the meeting date for review and final approval and then filed both in the home records and at the Main Office. The Director of Residential Services will maintain a comprehensive file for the meeting minutes and agendas.</p>	
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I 500	<p>Continued From page 6</p> <p>On January 28, 2014, at 1:30 p.m., the RN reviewed Resident #4's MARs and POS and confirmed the aforementioned findings. The RN stated she would seek clarification from the PCP regarding the prescribed administration time of both medications. On January 29, 2014, at 2:30 p.m., the RN said she had reviewed the resident's medication regimen with the PCP. The PCP had instructed the facility to administer Resident #4's Dilantin at 8:00 p.m. and the Senna was to be given with the other medications at 6:00 p.m.</p> <p>At the time of the survey, there was no evidence that the supervisory RN had reviewed the designated medication administration times, and clarified orders when indicated, to ensure compliance with physician's orders.</p> <p>II. [483.440(f)(3)(i)] The GHIID failed to show evidence that Resident #4's BSP and psychotropic medications had been reviewed and/or approved by the Human Rights Committee, as follows:</p> <p>On January 27, 2014, at approximately 9:20 a.m., FM #1 stated that Resident #4's BSP included the use of psychotropic medications. At 9:37 a.m., FM #1 stated that she would make available for review the minutes of the facility's HRC meetings from the past 12 months.</p> <p>On January 28, 2014, at 9:50 a.m., review of Resident #4's current POS (January 2014) confirmed that the resident received psychotropic medications. The POS and the resident's monthly psychotropic medication review forms reflected the daily administration of Prozac 60</p>	I 500		

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I 500	<p>Continued From page 7</p> <p>mg and Revia 50 mg. Continued review of Resident #4's record revealed no evidence that the HRC had reviewed and approved the resident's BSP.</p> <p>On January 28, 2014, at 12:00 p.m., QIDP #1 agreed to the second request for HRC minutes and documentation. No additional information was made available for review before the survey ended the next day at 3:22 p.m.</p> <p>At the time of the survey, there was no evidence that the facility's HRC had reviewed and approved Resident #4's BSP that incorporated the use of Prozac and Revia.</p>	I 500		