

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

PRINTED: 02/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2013
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019	
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W 000	INITIAL COMMENTS A recertification survey was conducted from February 6, 2013 through February 8, 2013. A sample of three clients was selected from a population of five women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations in the home and at two day programs, staff at the home and at the two day programs, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an incident of client to client abuse and an injury of unknown origin were thoroughly investigated, for two of the five clients in the suevey. (Clients #1 and #4) The findings includes: On February 7, 2013, beginning at 2:00 p.m., a review of facility incidents and investigation revealed the following: a. An incident report dated February 22, 2012,	W 154	As indicated, an investigation was completed for the incident mentioned but on an improper form. The certified investigators have been trained and are completing all incidents on the required form at this time...3-1-13 The IMC reviews all investigations to ensure they are completed properly and on the proper forms prior to submission...3-1-13	

Received 3/8/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Wanda P. Edwards for Evette Moore* TITLE: *DRS* (X6) DATE: *3/8/13*

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 154	Continued From page 1 revealed Client #3 pushed Client #4. As a result both clients fell and Client #4 sustained an injury to her lip. b. On March 3, 2012, the direct support staff (Staff #3) observed "discoloration on Client #1's right upper arm. Continued review of the February 22, 2012 and March 1, 2012, incident reports revealed a recommendation was made for each incident. There was however, no evidence that an investigation was completed. Interview with the qualified intellectual disabilities professional (Staff #1) revealed she was using the wrong format to conduct investigations. Further interview revealed she was trained on a new format "last month" and is currently using the new format. At the time of the survey, there was no documented evidence that the aforementioned incidents had been investigated.	W 154		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the nursing staff obtained timely pap smear results for one of the three clients in the sample. (Client #2) The finding includes:	W 322	The RN will follow up to obtain the results of the Pap smear...3-4-13 The RN will use tracking forms provided by the DON to track all required medical follow up documentation in a proactive manner; the assigned RN will begin using formal tracking formats by...3-15-13 Additionally, the DON will follow up formally with the nurses operating the MTS nursing office to ensure they are providing effective back up support for tracking and receiving important medical consultation information...3-15-13	

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W 322	Continued From page 2 Record review on February 7, 2013, beginning at 9:28 a.m., revealed Client #2 received a pap smear on June 11, 2012. The gynecologist consult stated that the results were pending. (8 months later) Interview with the director of nursing (RN #2) on February 8, 2013, at approximately 1:15 p.m., revealed that the facility did not have the results of the pap smear. The facility's nursing services failed to obtain Client #2's pap smear results timely.	W 322		
W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide immunization results for tuberculosis screening as determined necessary by the physician, for one of the three clients in the sample. (Client #2) The finding includes: Review of Client #2's medical records on February 7, 2013, at 9:01 a.m., revealed a physician's medical assessment dated September 2012. The assessment noted Client #2's last tuberculosis screening was conducted	W 324	The tuberculosis screening results were documented but were not filed properly (see: attached documentation); the document has been properly filed...3-1-13	

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W 324	Continued From page 3 on August 18, 2010. When asked, the qualified intellectual disabilities professional (staff #1) presented a tuberculosis screening form dated November 15, 2012 for Client #2, however there was no results of the screening. Interview with the director of nursing (RN #2) on February 8, 2013, revealed that a tuberculosis screening is required yearly, however there was no evidence that Client #2 had a current screening.	W 324		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to ensure nursing quarterly reviews were conducted for three of three clients in the sample. (Clients #1, #2 and #3) The finding includes: Interview with the registered nurse (RN #1) consultant on February 6, 2013, at 8:20 p.m., revealed that she monitored the clients' health status in annual nursing assessments, health management care plans, and in problem oriented progress notes. During further interview with the RN #1 concerning nursing quarterly reports, she indicated that she was working on them and that they were not in the clients' records yet. The	W 336	The RN will complete the required quarterly reports by...3-30-13 The DON has met with the RN to stress the importance of completing this mandate on a consistent basis for everyone in the support cluster...3-1-13 The RN will develop a tracking format for 2013 and each year thereafter outlining the quarterly report schedule for each person in the support cluster...3-15-13 The QIDP will audit compliance monthly and will report findings to the DON for follow up as needed...3-15-13	

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W 336	<p>Continued From page 4</p> <p>director of nursing (DON/RN #2) stated that additional information should be available prior to the survey exit.</p> <p>-On February 7, 2013, at 10:02 a.m., record review revealed Client #2 ' s annual assessment dated September 5, 2012. Although the record revealed problem oriented progress notes, there were no quarterly nursing assessments available for 2012.</p> <p>- On February 7, 2013, at 5:17 p.m., record review revealed Client #1 ' s annual assessment dated April 23, 2012. The record revealed problem oriented progress notes, however, no quarterly nursing assessments were available.</p> <p>- On February 8, 2013, at 3:39 p.m., record review revealed Client #1 ' s annual assessment dated December 13, 2012. Although the record revealed problem oriented progress notes, there were no quarterly nursing assessments available for 2012.</p> <p>The director of nursing (DON/RN #2) was interviewed by telephone on February 8, 2012, at 11:37 a.m., to ascertain additional information about the quarterly nursing assesments. The DON stated that the RN# 1's consultant responsibilities included monitoring the clients' health status, conducting quarterly and annual nursing assessments, and maintaining the health management care plans. The DON stated that she trained RN #1 on the job responsibilities when she was assigned to provide nursing services for the clients. The DON indicated that a record of the training on the job responsibilities was not available for review onsite at the time of</p>	W 336		

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W 336	Continued From page 5 the survey. However, the DON stated that the RN #1 's agreement did include conducting the quarterly nursing reviews. On February 8, 2013, at 4:18 p.m., review of the RN #1 's consultant agreement dated July 3, 2012, revealed quarterly nursing reviews are developed as prescribed, and include systems review and review of chronic and acute concerns. At the time of the survey, the facility failed to ensure quarterly nursing assessments were conducted for the clients as required.	W 336		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure the medication administration was accurately recorded on the medication administration record (MAR) for one of three clients in the sample. (Client #2) The finding includes: Observation of the medication administration on February 6, 2013, beginning at 7:33 p.m., revealed Client #1 was observed to receive Calcium, Polyethylene Glycol, and generic Debrox from the evening licensed practical nurse (LPN #1). Review of Client #2's medication administration records (MAR) on February 7, 2013, beginning at 10:23 a.m., revealed the following:	W 365	MTS has changed personnel in the last year because the LPNs terminated made repeated errors in documentation of medication administration...3-1-13 The existing LPN pool of medication passing nurses will be retained by the assigned RN or DON to ensure that there is consistency in documentation and medication passing...3-15-13 The QIDP and Facility Manager will check the MARs on alternating weeks to ensure weekly reviews and will report any deficiencies found to the Assigned RN or DON...3-1-13 The assigned RN will review the MARs monthly at minimum and will address issues discovered with the relevant nurses...3-1-13 The MAR book will be maintained in a locked area assessable only to the RN, DON and nursing supports effective...3-5-13	

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W 365	Continued From page 6 - January 2013, MAR revealed there were no initials documented that indicated the client was administered the evening aforementioned medications on January 5, 2013; - October 2012, MAR revealed there were no initials documented that indicated the client was administered Polyethylene Glycol on October 20, 2012; - November 2012, MAR revealed there were no initials documented that indicated the client was administered Polyethylene Glycol on November 2 and 9, 2012; - May 2012 MAR revealed there were no initials documented that indicated the client was administered deep sea nasal spray on May 26 and 27, 2012; and - The MAR's for March 2012 and April 2012 were not available for review. Continued review of the MARs for January 2013, May, October and November 2012 on February 7, 2013, revealed that there was no information documented on the back of the MARs to explain why the initials were missing. Interview with the director of nursing (RN #2) on February 8, 2013, at 12:30 p.m., revealed that the MAR's required an initial when medication is administered and a written explanation on the back of the MAR's when medication is not given. Further interview at 4:00 p.m revealed Client #2's evening medication was not administered on January 5, 2013, however she was not aware if	W 365			

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W 365	Continued From page 7 the client was administered medications for the remaining aforementioned dates. The director of nursing (RN #2) also stated that she did not have the MAR's for March and April 2012.	W 365		
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, interview, and record review, the facility failed to ensure a recommended wheelchair and shoe inserts were provided for two of three clients in the sample. (Client #1 and #3) The finding includes: 1. On February 6, 2013, at 6:45 p.m., Client #1 was observed to ambulate with a slight limp, as she took her plate to the kitchen sink. Closer observation of the client revealed she was wearing high top supportive sneakers. Interview with the qualified intellectual disabilities professional (QIDP) on February 7, 2013, at 1:10 p.m., revealed Client #1 did not require an assistive device for mobility, however does wear a supportive ankle brace daily as recommended by the orthopedist. Interview with direct support staff (Staff #3) on February 8, 2013, at 4:30 p.m., indicated that Client #1 did not use any type of	W 436	The necessary 719A has been completed, signed by the PCP and submitted. The wheelchair will be obtained by...3-30-13 In the meantime, MTS will provide a loaner to Client #1 until her own chair is obtained...3-5-13 The 719A for the custom shoe insert has been completed, signed and submitted...3-4-13 The insert will be obtained by 3-30-13 The new QIDP and assigned RN will collaborate to review and update the status of all adaptive equipment for each person supported and to update the standard documentation forms for ongoing internal use and submission to DDS for monthly reporting purposes...3-30-13 The Adaptive Equipment Tracking Forms will be updated no less than monthly and within a week of any newly identified need...3-15-13	

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W 436	<p>Continued From page 8 adaptive equipment for mobility.</p> <p>On February 8, 2013, at 4:10 p.m., review of Client #1's orthopedic consultation report dated April 10, 2012, revealed a diagnosis of severe right ankle arthritis. A lace up ankle brace and follow-up as needed were recommended by the orthopedist. Review of a physical therapy assessment (PT) dated April 20, 2012, at 4:42 p.m., revealed the client demonstrated balance and safety reactions, however, was at risk for falls. Standby assistance in the community was recommended to prevent falls. Additionally, the PT assessment recommended to purchase a wheelchair for the client to use in the community for extended outings like the zoo, amusement parks and vacations.</p> <p>On February 8, 2012, at 4:45 p.m., further interview with the QIDP revealed that through oversight, the requisition for Client #1's recommended wheelchair for distance travel was not submitted. At the time of the survey, there was no evidence that a wheelchair was provided for Client #1.</p> <p>2. Observation on February 7, 2013, at approximately 8:45 a.m., revealed Client #3 was walking with an unsteady gait. The client staggered and walked at a slow pace. Continued observation revealed the client required physical assistance to ascend and descend the stairs.</p> <p>On February 8, 2013, at 10:01 a.m., review of the PT assessment dated December 12, 2012, revealed a recommendation to "generate a signed 719 A for a new custom shoe insert to accommodate her plantar flexion contractures.</p>	W 436			

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W 436	Continued From page 9 pes planus, and forefoot varus". Continued review of the physical therapist assessment revealed the client will require extra depth shoes to accommodate the shoe insert. Interview with the director of nursing (RN #2) on February 8, 2013, at approximately 1:00 p.m., revealed she was not aware of the status of the aforementioned 719 A request. Further interview revealed she will follow up on the request. The facility's nursing services failed to address the December 12, 2012, PT recommendation to generate a signed 719 A request for Client #3's custom shoe insert at the time of survey.	W 436			

Health Regulation & Licensing Administration		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2013
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019
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1 000	INITIAL COMMENTS A licensure survey was conducted from February 6, 2013 through February 8, 2013. A sample of three residents was selected from a population of five women with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at two day programs, interviews with staff at the home and at two day programs, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000		
1 071	3503.2 BEDROOMS AND BATHROOMS 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. This Statute is not met as evidenced by: Based on observation, and interview, the group home for individuals with intellectual disabilities (GHID) failed to ensure a distance of at least three feet between resident beds was maintained, for two of five residents in the facility. (Residents #4 and #5) The finding includes: Observation on February 7, 2013, at 11:22 a.m., revealed the space between Residents #4 and #5's twin beds appeared to be less than the required three feet (36 inches). On February 8, 2013, at 10:40 a.m., the surveyors measured the	1 071	MTS via the facility manager and QIDP will rearrange the room so that the beds are at minimum 36 inches apart and the closet can be used for storage...3-20-13	

Health Regulation & Licensing Administration
Freda C. Edward for Erelte Moore TITLE *DB*
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 (X6) DATE *3/8/13*

Health Regulation & Licensing Administration

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I 071	Continued From page 1 space between the two beds and determined that it was 31 inches wide. Interview with the house manager (Staff #2) on February 7, 2013, at 11:55 a.m., revealed the individuals beds were placed parallel to each other and directly against the walls to maximize the amount of space between the beds. Resident #4's bed was observed to positioned in a manner that prevented the closet door from opening. On February 7, 2013, at 11:59 a.m., Staff #2 notified the facility's qualified intellectual disabilities professional (QIDP/Staff #1) of the aforementioned concern. Staff #2 stated that she would attempt to rearrange the furniture to ensure that there was three feet between the twin beds. The Staff #1 indicated that the director of residential services would also be notified of the concern. At the time of the survey exit, there was no evidence that each client's bed in the facility was placed at least three feet from any other bed, as required.	I 071	3504.1 1. Repairs completed on kitchen floor tiles... a. Repairs completed on kitchen floor tiles...3-1-13 b. Will be completed by...3-16-13 c. Will be completed by...3-9-13 2. The bathroom will be re-caulked by...3-16-13 3. Will be repaired by...3-23-13 4. Handles will be replaced by...3-9-13 5. Lamp shade replaced by...3-9-13 B. (Exterior) 1. The area will be scrapped and repainted in the early spring (not feasible during cold weather)...5-15-13 2. Tree debris will be removed...3-09-13 3. Repair completed by...3-9-13 4. Nailed down during survey process...2-28-13	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP 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 interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that the interior and exterior of the facility were maintained in a safe	I 090	The new Home and Vehicle Maintenance Consultant is auditing each home location monthly (interior and exterior) and will monitor and address such concerns in the process...3-1-13 MTS has established a new 32 hour weekly Home and Vehicle Maintenance position that has been filled and is charged with the ongoing monitoring and proactive follow up on home and vehicle concerns...3-1-13	

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
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I 090	Continued From page 2 and orderly manner for five of five residents in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: On February 8, 2013, beginning at 10:37 a.m., the house manager, Staff #2, accompanied the surveyor to conduct environmental observations. A. The following concerns were identified in the interior of the facility. 1. Damaged and broken floor tiles were observed in the following areas of the facility. a. kitchen (various areas and in the doorway leading from the dining room to the kitchen) b. laundry room (near the washing machine) c. living room (on the right side of the fireplace) The broken tiles created potential tripping hazards. 2. The caulking applied to seal the hand sink to the wall was heavily cracked, in the bathroom located on the first floor. 3. There was a hole in the window where the dryer vent pipe was installed. Additionally, the pipe was partially disconnected from the dryer vent cover. 4. Handles were missing from three of four doors on the storage units located in the basement recreation room. Screws were observed to protrude from two of the three doors, where the handles were missing. 5. The shade on the lamp on the table in the sitting room in the basement, had a large hole in it.	I 090		

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I 090	<p>Continued From page 3</p> <p>B. The following concerns were identified on the exterior of the facility.</p> <p>1. Heavily scaling paint was observed at the right front of the facility, above the bricked area. This area was located above the front bedroom window of Residents #1 and #3.</p> <p>2. The remains of a small tree that had been cut down, were laying in the flower bed at the right front corner of the facility. In the same flower bed, the remains of a small tree protruded approximately one foot above the ground.</p> <p>3. The dryer vent cover was partially detached from the dryer vent pipe, which exited through a broken window in the laundry room.</p> <p>4. Observation of the wheelchair access ramp, revealed numerous nails protruded above the boards. Doors from the bedrooms of Residents #1 and #3, and also of Resident #2 exited onto the ramp. The ramp proceeded around the corner of the house to the walkway in the back yard. Prior to the survey exit, staff hammered the nails downward until they were even with the boards. At the time of the survey, however there was no evidence that the nails in the ramp had been closely monitored to ensure that the heads remained level with the boards.</p> <p>Interview with Staff #2 on February 8, 2012, at 11:28 a.m., revealed the identified concerns would be reported to the management. Staff #2 indicated that if the concerns could be addressed, they would be managed prior to the survey exit.</p>	I 090	<p style="text-align: center; font-size: 24px;">3509.6</p> <p>1/2. Health certificates for staff members #4 and #5 were not properly filed but are attached...3-1-13</p> <p>3/6</p> <p>The RN and Nutritionist health certificates are attached; the pharmacist have been submitted with the responses (see: attachments)...3-1-13</p> <p>The pharmacist has been notified and will be obtained by...3-15-13</p> <p>The two LPNs have been notified and must submit updated health certificates by...3-15-13</p> <p>Or be removed from the support schedule...3-15-13</p> <p>Tracking and proactive notification is ongoing and MTS is establishing a travel book that will contain all needed personnel files for each clinical professional; it will be presented for each subsequent survey and will be used to track ongoing compliance across all concerns...3-15-13</p>	
I 206	3509.6 PERSONNEL POLICIES	I 206		

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I 206	<p>Continued From page 4</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 group home for individuals with intellectual disabilities (GHIID) failed to ensure that all employees and health care professionals had current health certificates on file, for 2 of 11 direct support staff (Staff #4 and #5), 2 of 3 licensed practical nurses. (LPN #1 and #2), 2 of 2 registered nurse (RN #1 and RN #2), and 2 of 8 consultants (Consultants #1 and #2).</p> <p>The findings include:</p> <p>On February 8, 2013, beginning at 4:02 p.m., review of the personnel records for all employees, including licensed professionals revealed the following:</p> <ol style="list-style-type: none"> 1. There was no evidence of a current physician's health inventory/certificate for Staff #4. Staff #4 did however have evidence of a screening for tuberculosis. 2. There was no evidence of a physician's health inventory/certificate for Staff #5. 3. There was no evidence of a physician's health inventory/certificate for LPN #1 and #2. 4. There was no evidence of a physician's health 	I 206		

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I 206	<p>Continued From page 5 inventory/certificate for RN #1 and #2.</p> <p>5. There was no evidence of a physician's health inventory/certificate for the nutritionist (Consultant #1).</p> <p>6. There was no evidence of a physician's health inventory/certificate for the pharmacist (Consultant #2).</p> <p>Interview with the qualified intellectual disabilities professional (Staff #1) on February 8, 2013, at approximately 5:00 p.m., revealed she will retrieve the aforementioned documents from the human resource director.</p> <p>At the time of the survey however, the GHIID failed to provide evidence of the aforementioned documents.</p>	I 206		
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR) for one of two registered nurses (RN #2), and one of three licensed practical nurses. (LPN #1)</p> <p>The finding includes:</p>	I 227	<p>RN #2's CPR certification is attached...3-1-13 LPN #1's CPR certification will be obtained by...3-15-13</p>	

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I 227	Continued From page 6 Review of the personnel records on February 8, 2013, beginning at 4:02 p.m., revealed the GHPID failed to have available for review a current CPR certification for RN #2 and LPN #1. This was acknowledged by the qualified intellectual disabilities professional (Staff #1) on the same day at approximately 5:00 p.m.	I 227		
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to obtain a written report at least quarterly for nursing services provided during the preceding quarter, for three of three residents in the sample. (Residents #1, #2, and #3) The finding includes: Interview with the registered nurse (RN #1) consultant on February 6, 2013, at 8:20 p.m., revealed that she monitored the residents' health status in annual nursing assessments, health management care plans, and in problem oriented progress notes. During further interview with the RN #1 concerning nursing quarterly reports, she indicated that she was working on them and that they were not in the residents' records yet. The director of nursing (DON/RN #2) stated that additional information should be available prior to the survey exit.	I 407	The RN will complete the required quarterly reports by...3-30-13 The DON has met with the RN to stress the importance of completing this mandate on a consistent basis for everyone in the support cluster...3-1-13 The RN will develop a tracking format for 2013 and each year thereafter outlining the quarterly report schedule for each person in the support cluster...3-15-13 The QIDP will audit compliance monthly and will report findings to the DON for follow up as needed...3-15-13	

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I 407	<p>Continued From page 7</p> <p>-On February 7, 2013, at 10:02 a.m., record review revealed Resident #2 's annual assessment dated September 5, 2012. Although the record revealed problem oriented progress notes, there were no quarterly nursing assessments available for 2012.</p> <p>- On February 7, 2013, at 5:17 p.m., record review revealed Resident #1 's annual assessment dated April 23, 2012. The record revealed problem oriented progress notes, however, no quarterly nursing assessments were available.</p> <p>- On February 8, 2013, at 3:39 p.m., record review revealed Resident #1 's annual assessment dated December 13, 2012. Although the record revealed problem oriented progress notes, there were no quarterly nursing assessments available for 2012.</p> <p>The director of nursing (DON/RN #2) was interviewed by telephone on February 8, 2012, at 11:37 a.m., to ascertain additional information about the quarterly nursing assesments. The DON stated that the RN# 1's consultant responsibilities included monitoring the residents' health status, conducting quarterly and annual nursing assessments, and maintaining the health management care plans. The DON stated that she trained RN #1 on the job responsibilities when she was assigned to provide nursing services for the residents. The DON indicated that a record of the training on the job responsibilities was not available for review onsite at the time of the survey. However, the DON stated that the RN #1's agreement did include conducting the quarterly nursing reviews.</p> <p>On February 8, 2013, at 4:18 p.m., review of the</p>	I 407			

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1407	Continued From page 8 RN #1 's consultant agreement dated July 3, 2012, revealed quarterly nursing reviews are developed as prescribed, and include systems review and review of chronic and acute concerns. At the time of the survey, the facility failed to ensure quarterly nursing assessments were conducted for the residents as required.	1407		