

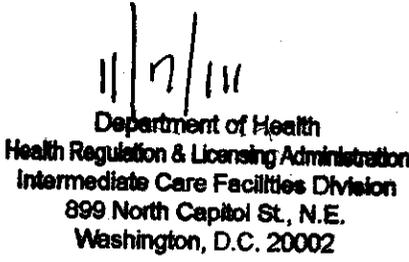
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

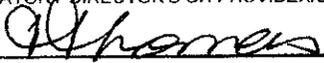
PRINTED: 10/25/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/06/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC 08</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1600 FRANKLIN STREET, NE WASHINGTON, DC 20017</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from 10/4/2011 through 10/6/2011. A sample of three clients was selected from a population of five women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations and interviews with staff and clients in the home and at one day program, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000	<p style="text-align: center;">11/7/11                    Department of Health                  Health Regulation &amp; Licensing Administration                  Intermediate Care Facilities Division                  899 North Capitol St., N.E.                  Washington, D.C. 20002</p>	
W 234	<p>483.440(c)(5)(i) <b>INDIVIDUAL PROGRAM PLAN</b></p> <p>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that written training programs specified the methods to be used to ensure proper implementation of the programs, for one of the three clients in the sample. [Client #3]</p> <p>The finding includes:</p> <p>On 10/4/2011, at 4:10 p.m., Client #3 was sitting in the living room watching television. At 4:25 p.m., the client got up and ran into the bathroom where she was observed turning on the faucet water and putting her face to the faucet. The</p>	W 234		7/1/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  <b>CEO</b>	(X6) DATE  <b>11/7/11</b>
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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 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 234	<p>Continued From page 1</p> <p>direct support staff entered the bathroom and asked the client to stop and directed her to return to the living room and the client complied.</p> <p>On 10/4/2011, at 4:35 p.m., in an interview with the direct support staff it was revealed that the client had a behavior of excessive water drinking and, therefore was on a water drinking schedule.</p> <p>Review of Client #3's behavior support plan (BSP) dated 7/11/2011, on 10/6/2011, at approximately 10:00 a.m., revealed proactive strategies that staff must:</p> <ul style="list-style-type: none"> <li>- follow water drinking schedule;</li> <li>- provide frequent casual verbal praise;</li> <li>- provide close supervision; and</li> <li>- provide client with a schedule of structured activities.</li> </ul> <p>Further review of Client #3's BSP on 10/6/2011, at approximately 10:20 a.m., revealed no written directions/intervention strategies to guide staff if/when an incident occurs. The qualified intellectual disabilities professional (QIDP) was interviewed at 10:45 a.m., to ascertain information regarding what staff should do when the client drinks water outside of her water drinking schedule. The QIDP confirmed that there were no written directions/intervention strategies outlined in the client's BSP.</p>	W 234	<p>Client #3's BSP has a section on crises intervention. Pls see pg. 5, #3 that dictates that nurses must be notified if client consumes excessive amounts of water despite staff supervisory attempts. Staff have been trained as BSP as noted in attachment. All staff are trained on BSP including intervention strategies as needed.</p>	7/11/11
W 325	<p>482.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum</p>	W 325		

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W 325	<p>Continued From page 2</p> <p>includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure routine laboratory testing as determined necessary by the physician, for one of the three clients in the sample. [Client #3]</p> <p>The finding includes:</p> <p>On 10/4/2011, beginning at 7:47 a.m., Client #3 was observed being administered Klonopin, Neurontin and Amantadine. During the medication administration, the trained medication employee (TME) indicated that the medications were used to address the client's maladaptive behaviors.</p> <p>On 10/5/2011, beginning at 9:45 a.m., review of Client #3's physician's orders (POS) dated from October 2010 through October 2011, revealed a lab order for the client to receive a HGA1C laboratory study every six months. Subsequent review of her medical records revealed that her HGA1C levels were obtained on 10/15/2010 and 11/29/2010.</p> <p>Interview with the registered nurse (RN) on 10/5/2011, at approximately 11:30 a.m., confirmed that the studies were not completed every 6 months as ordered.</p> <p>The facility's nursing services failed to maintain an effective system to ensure that clients'</p>	W 325	<p>Labs have been done and are now current RN has reviewed all individuals labs and verified all current. RN will review all labs on a quarterly basis to ensure that all labs are current.</p>	9/7/11

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W 325	Continued From page 3 laboratory studies were performed at the frequencies ordered by the primary care physician.	W 325			
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 (POS), for one of five clients residing in the facility. [Client #5]  The finding includes:  [Cross-refer to W369] On the morning of 10/4/2011, Client #5 was not observed receiving her Flonase nasal spray in accordance with the POS.  The facility failed to ensure that nursing services provided effective and consistent monitoring of all medication to ensure accurate administration at all times.	W 368	<i>THE has been retrained to ensure proper administration of medication in compliance with physicians orders. All MARs have been reviewed to ensure medication was administered in compliance with physicians orders. RN will review all MARs on a monthly basis to ensure drugs are administered per physicians orders. RN will observe med pass at least once per month and cross reference against MARs to ensure compliance</i>	<i>10/5/11 10/7/11</i>	
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	W 369	<i>see W 368</i>	<i>10/05/11 10/7/11</i>	

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W 369	<p>Continued From page 4</p> <p>review, the facility failed to ensure that all drugs were administered without error, for one of the five clients residing in the facility. [Client #5]</p> <p>The finding includes:</p> <p>The morning medication administration was observed on 10/4/2011. At 7:00 a.m., the trained medication employee (TME) entered the facility, introduced herself and went to the basement. At 7:03 a.m., the TME washed her hands, unlocked the medicine cabinet and called upstairs for staff assistance. The TME administered medications to Clients #2, #1, #4 and #3 during the 39 minutes that followed.</p> <p>At 7:42 a.m., the TME began pouring Client #5's medications and she called upstairs for the client. At 7:45 a.m., Client #5 came downstairs, hugged the TME, sat down, took the cup of medications from the TME and swallowed her medications. The client then drank water while the TME started documenting in Client #5's medication administration record (MAR). The client went back upstairs after she finished the water. Shortly thereafter, the TME stated that she was through administering all clients' medications. At 7:57 a.m., this surveyor went back upstairs and observed the five clients entering a van that was parked in the driveway.</p> <p>On 10/4/2011, at 3:51 p.m., review of Client #5's physician's order sheets (POS) dated October 2011, revealed the physician ordered "Fluticasone Propionate 120 metered sprays 50 mcg spray suspension (Flonase), 1 in each nostril every morning for sinusitis/ rhinorrhea." Concurrent review of her October 2011 MAR</p>	W 369			

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W 369	Continued From page 5 revealed that the space for documenting administration of the nasal spray had been left blank on that morning, as well as on the mornings of 10/1/2011, 10/2/2011 and 10/3/2011. The October MAR did not specify a designated time for the morning administration; however, review of her September 2011 MAR revealed the TMEs had documented administration of her nasal spray at 7 a.m. every morning previously. Further record review revealed no indication that her nasal spray had been discontinued.  On the morning of 10/4/2011, Client #5 was not observed receiving her Flonase nasal spray as prescribed by her physician.  This is a repeat deficiency.  See Federal Deficiency Report, dated 10/15/2010.	W 369		
W 375	483.460(k)(8) DRUG ADMINISTRATION  The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that drug administration errors were recorded for one of the five clients residing in the facility. [Client #5]  The finding includes:  During the morning medication administration on 10/4/2011, the trained medication employee (TME) failed to administer Client #5's Flonase	W 375	Incident report was generated (see attached) and all required parties including PCP were notified and observed individual TME's were re-trained with no adverse effects by RN - (see attached) on accurate administration and documentation of all meds to all individuals and facilities medication administration policy	10/6/11

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W 375	<p>Continued From page 6</p> <p>nasal spray. On 10/4/2011, at 3:51 p.m., review of Client #5's physician's order sheets, dated October 2011, revealed the physician ordered "Fluticasone Propionate 120 metered sprays 50 mcg spray suspension (Flonase), 1 in each nostril every morning for sinusitis/ rhinorrhea." Concurrent review of her October 2011 medication administration record (MAR) revealed that the spaces for documenting administration of the nasal spray were left blank on that morning, and the mornings of 10/1/2011, 10/2/2011 and 10/3/2011.</p> <p>On 10/5/2011, at approximately 9:50 a.m., review of the client's MAR revealed initials now documented that the medication was administered on 10/1/2011, 10/2/2011, 10/3/2011 and 10/4/2011. A moment later, interview with the registered nurse (RN) revealed that she and the licensed practical nurse (LPN) Coordinator had examined Client #5's MAR after this surveyor photocopied it on the previous evening. According to the nurses, they asked their two TMEs if they had administered the Flonase. When the TMEs answered yes, their initials were placed on the MAR. Immediately, the RN, LPN Coordinator and several witnesses were informed that the TME was observed from the time she entered the facility at 7:00 a.m. until Client #5 and her peers left the facility at 7:57 a.m., and at no time was she observed administering Client #5's nasal spray on 10/4/2011.</p> <p>On 10/6/2011, beginning at 10:24 a.m., a follow-up interview with the RN and LPN Coordinator revealed that the missed administration of Client #5's Flonase on the morning of 10/4/2011, was not recorded in the</p>	W 375			

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W 375 Continued From page 7  
client's record. The client's MAR did not reflect either the missed administration or any indication that the TMEs' initials had been late entries. The RN further stated that no incident report was generated after they were informed that Client #5 did not receive her nasal spray. Further review of the client's record failed to show evidence that the medication error had been recorded.

It should be noted that on 10/6/2011, beginning at 11:39 a.m., review of the facility's Medication Administration Policy revealed the following:

"The missed administration shall be recorded and completed as to the date, the prescribed time missed, the time administered, the observed side effects of the missed, the time administered, the observed side effects of the time administered (if any), the reasons for the missed administration and Incident Reporting Protocol followed."

W 381 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING

The facility must store drugs under proper conditions of security.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that controlled substances were stored under double locks, for one of the three clients in the sample. [Client #3]

The finding includes:

On 10/4/2011, beginning at 7:47 a.m., the trained medication employee (TME) was observed administering Klonopin 0.5 mg to Client #3. On

W 375

W 381

TME was retrained by RN on requirements including drug storage. All TMEs were also retrained on Drug Storage and recordkeeping. QPDP will conduct random checks to ensure that drug storage meets requirements. \*LPN confirmed that the cabinet was not double

10/5/11  
10/7/11

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W 381	<p>Continued From page 8</p> <p>the same day, at 2:40 p.m., a drug controlled substance count was conducted. The licensed practical nurse (LPN) was observed unlocking a file cabinet that contained Client #3's medications. The Klonopin was observed with her other medications, stored openly on a shelf.</p> <p>Interview with the LPN, on 10/4/2011, at 2:40 p.m., revealed that Schedule II controlled substance medications such as Klonopin should be stored under double lock. The LPN acknowledged that the Klonopin was not properly secured.</p> <p>Review of the agency's policy on 10/5/2011, at approximately 11:15 a.m., confirmed the LPN's statement regarding double locks.</p>	W 381	<p>locked. TME was the <del>out</del> last person to access the cabinet.</p>

Health Regulation & Licensing Administration

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1 000	INITIAL COMMENTS  A licensure survey was conducted from 10/4/2011 through 10/6/2011. A sample of three residents was selected from a population of five women with various intellectual and developmental disabilities.  The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, 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		
1 075	3503.3(d) BEDROOMS AND BATHROOMS  Each bedroom shall be equipped with at least the following items for each resident:  (d) Night stand.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure one of three sampled residents was provided a night stand. (Resident #3)  The finding includes:  Observation and interview with the facility's house manager (HM) on 10/4/2011, at approximately 2:45 p.m. revealed Resident #3 was not provided a night stand. Her other roommates (Residents #2 and #4) were provided the accommodation of a night stand.	1 075		

*Nightstands have been provided for all individuals. HM will conduct a regular check to ensure all individuals are provided with all required items. 10/5/11 10/7/11*

Health Regulation & Licensing Administration

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

*J. Thomas*

TITLE

CEO

(X6) DATE

11/7/11

Health Regulation & Licensing Administration

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I 075	Continued From page 1  The facility's HM indicated she would meet with the maintenance staff to ensure the night stand be provided to Resident #3 as quickly as possible.	I 075	
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 staff interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the facility's environment was maintained as required to ensure the health and safety of five of five residents. [Residents #1, #2, #3, #4 and #5]  The findings include:  Observation and interview with the facility's maintenance personnel on 10/4/2011, at 2:30 p.m., revealed the following deficient conditions:  1. Resident #2's closet door was broken and coming off the wall. The guiding tracks that should be in the wall over the closet doors were missing. There was no way to properly shut the closet doors.  2. Resident #3's closet door was also broken and was not able to open and shut properly. The guide track on the wall above the closet door was broken and not screwed in properly. In addition,	I 090	<p>1. Closet door has been repaired 10/7/11</p> <p>2. Closet door has been repaired 10/7/11</p> <p>House manager will conduct regular checks to ensure</p>



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I 260	Continued From page 3	I 260	<p>is current and on file. Please see attached Management is unclear as to which employees are being referred to.</p> <p>1260 see <del>1260</del></p> <p>TME'S have been retrained to ensure all residents' MAR'S are current and accurate. Residence director will ensure that MAR'S are reviewed on a regular schedule to ensure current and accurate records and reports are maintained. RN will also review records on a monthly basis to ensure they are current and accurate.</p>	8/4/11
I 260	<p>3512.1 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each Residence Director shall maintain current and accurate records and reports as required by this section.</p> <p>This Statute is not met as evidenced by: Based on interview and record verification, the group home for persons with intellectual disabilities (GHPID) failed to ensure the maintenance of each resident's record to make certain they were current and accurate, for one of the five residents of the facility. [Resident #5]</p> <p>The findings include:</p> <p>The GHPID's trained medication employees (TMEs) failed to maintain Resident #5's MARs, as follows:</p> <p>The morning medication administration pass was observed on 10/4/2011. At 7:00 a.m., the TME entered the facility, introduced herself and went to the basement. She washed her hands, unlocked the medicine cabinet and called upstairs for staff assistance. The TME administered medications to Residents #2, #1, #4 and #3 during the 39 minutes that followed.</p> <p>At 7:42 a.m., the TME began pouring Resident #5's medications and she called upstairs for the resident. At 7:45 a.m., Resident #5 came downstairs, hugged the TME, sat down and took her medications. The resident then drank water while the TME started documenting in Resident #5's MAR. The resident went back upstairs after she finished the water. Shortly thereafter, the TME stated that she was through administering all residents' medications. At 7:57 a.m., this</p>	I 260		10/5/11 10/7/11

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I 260	Continued From page 4  surveyor went back upstairs and observed the five residents entering a van that was parked in the driveway.  On 10/4/2011, at 3:51 p.m., review of Resident #5's physician's order sheets (POS) dated October 2011, revealed the physician ordered "Fluticasone Propionate 120 metered sprays 50 mcg spray suspension (Flonase), 1 in each nostril every morning for sinusitis/ rhinorrhea." Concurrent review of her October 2011 MAR revealed that the space for documenting administration of the nasal spray had been left blank on that morning, as well as on the mornings of 10/1/2011, 10/2/2011 and 10/3/2011. The October MAR did not specify a designated time for the morning administration. However, the space where nursing staff normally write the designated time had been marked with a pink highlighter, which was the color used to highlight other medications being administered in the morning (evening administration times were highlighted in green).  On 10/5/2011, at approximately 9:47 a.m., the RN and LPN Coordinator stated that they had examined Resident #5's MAR on the previous afternoon (after making a copy for the survey) and found the blank spaces. They subsequently contacted their two TMEs. Both TMEs reportedly said they had administered her Flonase each morning. The nurses further explained the TMEs' initials were added to the MAR afterwards, for the mornings of 10/1/2011, 10/2/2011, 10/3/2011 and 10/4/2011.  a. The TME that came to the facility the morning of 10/4/2011 was not observed to administer Resident #5's Flonase nasal spray during the time that she was in the GHPID (7:00 a.m. - 8:03	I 260	Corrective action has been taken to ensure that all medication administration documentation is consistent with best practices.	

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I 260	Continued From page 5  a.m.). Therefore, the TME's initials, which the nurses acknowledged had been added at a later time, were not accurate.  b. On 10/5/2011, at approximately 9:47 a.m., further review of Resident #5's MAR, front and back, found no TME or nurse notations to indicate that the TME initials placed for 10/1/2011, 10/2/2011, 10/3/2011 and 10/4/2011 were late entries, as was reported verbally by the nurses.	I 260	
I 401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure routine laboratory testing as determined necessary by the physician, for one of the three residents in the sample. [Resident #3]  The finding includes:  On 10/4/2011, beginning at 7:47 a.m., Resident #3 was observed being administered Klonopin, Neurontin and Amantadine. During the medication administration, the trained medication employee (TME) indicated that the medications were used to address the resident's maladaptive behaviors.	I 401	see w325  9/7/11

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I 401	Continued From page 6  On 10/5/2011, beginning at 9:45 a.m., review of Resident #3's physician's orders (POS) dated from October 2010 through October 2011, revealed a lab order for the resident to receive a HGA1C laboratory study every six months. Subsequent review of her medical records revealed that her HGA1C levels were obtained on 10/15/2010 and 11/29/2010.  Interview with the registered nurse (RN) on 10/5/2011, at approximately 11:30 a.m., confirmed that the studies were not completed every 6 months as ordered.  The facility's nursing services failed to maintain an effective system to ensure that residents' laboratory studies were performed at the frequencies ordered by the primary care physician.	I 401		
I 470	3522.1 MEDICATIONS  Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all drugs were administered as set forth in DC Code, 22-6100, for one of the five residents residing in the facility. [Resident #5]  The findings include:	I 470		

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I 470	Continued From page 7  1. The GHPID failed to ensure that all drugs were administered without error, as follows:  The morning medication administration pass was observed on 10/4/2011. At 7:00 a.m., the trained medication employee (TME) entered the facility, introduced herself and went to the basement. At 7:03 a.m., the TME washed her hands, unlocked the medicine cabinet and called upstairs for staff assistance. The TME administered medications to Residents #2, #1, #4 and #3 during the 39 minutes that followed.  At 7:42 a.m., the TME began pouring Resident #5's medications and she called upstairs for the resident. At 7:45 a.m., Resident #5 came downstairs, hugged the TME, sat down, took the cup of medications from the TME and swallowed her medications. The resident then drank water while the TME started documenting in Resident #5's medication administration record (MAR). The resident went back upstairs after she finished the water. Shortly thereafter, the TME stated that she was through administering all residents' medications. At 7:57 a.m., this surveyor went back upstairs and observed the five residents entering a van that was parked in the driveway.  On 10/4/2011, at 3:51 p.m., review of Resident #5's physician's order sheets (POS) dated October 2011, revealed the physician ordered "Fluticasone Propionate 120 metered sprays 50 mcg spray suspension (Flonase), 1 in each nostril every morning for sinusitis/ rhinorrhea." On the morning of 10/4/2011, Resident #5 was not observed receiving her Flonase nasal spray as prescribed by her physician.  This is a repeat deficiency. See Federal Deficiency Report, dated	I 470	see W368	10/05/11 10/7/11

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I 470	Continued From page 8 10/15/2010.  2. Medication administration records (MARs) were not maintained accurately, as follows:  [Cross reference I470.1] On 10/4/2011, at 3:51 p.m., review of Client #5's October 2011 MAR revealed that the space for documenting administration of her generic Flonase nasal spray had been left blank on that morning, as well as on the mornings of 10/1/2011, 10/2/2011 and 10/3/2011.  3. 3. The GHPID failed to ensure oversight of TMEs by the registered nurse (RN), as follows:  On 10/6/2011, at 11:45 a.m., a request was made for evidence the RN had provided training for TMEs and observed the TMEs administering medications to clients. At 12:37 p.m., TME training records were presented; however, no other documentation was made available for review to verify that the RN had observed TMEs while they administered the residents' medications.	I 470	see I 260  17  Please see training documentation. Corrective action has noted above. - 1260	10/5/11 10/7/11
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, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all irregularities involving residents' drug regimens were reported to the prescribing physician, for one of the five residents of the facility. [Resident #5]	I 473	An incident report was generated and all the appropriate parties including PCP notified (see docs attached). Cross reference W375	10/6/11

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I 473	<p>Continued From page 9</p> <p>The finding includes:</p> <p>The morning medication administration pass was observed on 10/4/2011. At 7:00 a.m., the trained medication employee (TME) entered the facility, introduced herself and went to the basement. At 7:03 a.m., the TME washed her hands, unlocked the medicine cabinet and called upstairs for staff assistance. The TME administered medications to Residents #2, #1, #4 and #3 during the 39 minutes that followed.</p> <p>At 7:42 a.m., the TME began pouring Resident #5's medications and she called upstairs for the resident. At 7:45 a.m., Resident #5 came downstairs, hugged the TME, sat down, took the cup of medications from the TME and swallowed her medications. The resident then drank water while the TME started documenting in Resident #5's medication administration record (MAR). The resident went back upstairs after she finished the water. Shortly thereafter, the TME stated that she was through administering all residents' medications. At 7:57 a.m., this surveyor went back upstairs and observed the five residents entering a van that was parked in the driveway.</p> <p>On 10/4/2011, at 3:51 p.m., review of Resident #5's physician's order sheets (POS) dated October 2011, revealed the physician ordered "Fluticasone Propionate 120 metered sprays 50 mcg spray suspension (Flonase), 1 in each nostril every morning for sinusitis/ rhinorrhea."</p> <p>On 10/5/2011, at approximately 9:50 a.m., the RN and LPN Coordinator were informed, in the presence of the qualified intellectual disabilities professional (QIDP) and the house manager, that Resident #5 was not observed to receive Flonase</p>	I 473		
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I 473 Continued From page 10

nasal spray on 10/4/2011 while the TME and residents were in the facility (7:00 a.m. - 8:03 a.m.). The LPN Coordinator stated that she had telephoned the primary care physician (PCP) on the evening before, at 4:16 p.m.; however, she had not been able to speak with the PCP. She further indicated that she had left a message with the PCP's staff.

On 10/6/2011, at 10:38 a.m., the RN stated that she had not reported the alleged medication error (missed Flonase on 10/4/2011, and possibly 10/1/2011, 10/2/2011 and 10/3/2011) because the TME "said she did give it..." When asked, the LPN Coordinator stated that while she had spoken with staff at the PCP's office on the evening of 10/4/2011, she had not mentioned the Flonase, as she did not want to give detailed information over the telephone to a person she couldn't verify was authorized to receive confidential information. She and the QIDP acknowledged during the Exit conference, on 10/6/2011, that the PCP had not been informed of Resident #5's missed Flonase.

This is a repeat deficiency.

See Licensure Deficiency Report, dated 10/15/2010.

I 473

I 484 3522.11 MEDICATIONS

Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.

This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with

I 484

All medication has been checked to ensure labels are present and legible and still current. 10/6/11

TMEs have been retained to ensure medications are treated accordingly

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I 484	<p>Continued From page 11</p> <p>intellectual disabilities (GHPID) failed to remove from use medications with missing labels, for one of the five residents of the facility. [Resident #5]</p> <p>The finding includes:</p> <p>[Cross reference I0 ] The morning medication administration pass was observed on 10/4/2011. At 7:45 a.m., Resident #5 came downstairs, took her medications and went back upstairs. The resident left the facility later that morning and was not observed receiving her prescribed nasal spray (Fluticasone Propionate, for sinusitis).</p> <p>On 10/5/2011, at approximately 9:45 a.m., the facility's registered nurse (RN) unlocked the medicine cabinet and retrieved a bottle of Fluticasone Propionate nasal spray. The bottle was without a label. After looking through the cabinet, the RN stated that she was unable to locate the box in which it was originally packaged (and on which the pharmacy had affixed the label). She and the LPN Coordinator both indicated that the bottle belonged to Resident #5, as she was the only resident for which the medication was prescribed. They further indicated that their two TMEs alleged having administered the Fluticasone Propionate nasal spray on the preceding dates. The nurses removed the bottle from the medicine closet afterwards.</p>	I 484	<p><i>The specific regulations. RN will check medication on a monthly basis to ensure all documentation</i></p>	