	IT OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	<u>). 0938-0</u> SURVEY
	OF CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		09G153	B. WING			
AME OF	PROVIDER OR SUPPLIER	030133				26/2011
COMP			STRE	ET ADDRESS, CITY, STATE, ZIP (ODE	
				29 LONGFELLOW STREET NW ASHINGTON, DC 20011		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
W 000	INITIAL COMMEN	TS .	W 000			· · ·
	October 24, 2011 ti sample of two clien population of four n intellectual disabiliti utilizing the fundam to concerns in the a the process was ex at 11:05 a.m., to rev compliance in the C for Health Care Ser The findings of the s observations, interv the home and at two review of client and including incident re	survey were based on iews with staff and clients in o day programs, as well as a administrative records, ports.		Received II Department of Hee Health Regulation & Licensing A Intermediate Care Facilitie 899 North Capitol St., Washington, D.C. 20	aith Mininistration Is Division	
	Services, the State / the facility: (1) failed system had been de make certain that Cl were tested while fa: that Client #1 receive prescribed to ensure facility's practices, th Client #1. On Octob facility's administrate	Agency (SA) determined that to ensure that an effective eveloped and implemented to ient #1's blood glucose levels sting; and, (2) failed to ensure ed insulin injections as this health and safety. The herefore, posed likely harm to er 25, 2011, at 1:05 p.m., the or was notified of the				
	the facility's administ director of nursing er correction (POC) to a eopardy. The SA su the facility's administ	I, at approximately 5:00 p.m. rative assistant and their nailed to the SA a plan of address the immediate prvey team met onsite with rative assistant and the			- - - - - - - - - - - - - - 	
RATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT	TIPE	TITLE		X6) DATE

Any deficiency statement ending with an astersk (*) 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 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.

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					D: 11/10/2011
	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE	
		09G153	B. WI	NG_		1 10	10610044
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		/26/2011
СОМРО	AREII			1	NEET ADDRESS, CITT, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	<u>. </u>	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	 5:12 p.m. to 5:26 p.1 assistant and the DO proposed corrective be implemented imr dinner. An amended approximately 6:50 p implementation of the observed prior to the jeopardy. The following was the facility that outlined to measures: The registered nut #1's physician's order medication/treatmen Medication Administric health passport and a plan for accuracy and 2. The RN will ensured care staff are trained management/care. A 	DON) from approximately m. The administrative ON agreed to supplement the plan by adding measures to mediately that evening, before d POC was presented at p.m. Compliance and the corrected actions were a removal of the immediate are plan submitted by the the proposed corrective rse (RN) will review Client the proposed corrective rse (RN) will review Client the proposed corrective rse (POS), t, consult and tracking forms, ration Records (MARs), health management care d completeness. e that all nursing and direct in diabetic All nursing staff will receive ctober 26, 2011, to include: ining, medication ian/RN notification, Comprehensive Care	W				
	3. The RN will ensure are scheduled and co will be forwarded to th (PCP) for review. All	e all medical appointments ompleted. Consult orders ne primary care physician verbal orders will be for review/signature within		· · · · · · · · · · · · · · · · · · ·			

Facility ID: 09G153

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ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	09G153		B. WI	NG	······································	40"	36/0044
	IAME OF PROVIDER OR SUPPLIER			132	ET ADDRESS, CITY, STATE, ZIP CODE 29 LONGFELLOW STREET NW ASHINGTON, DC 20011	<u>10/26/201</u> E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OFFI D RE	(X5) COMPLETION DATE
	 The onsite nurse verbal/written report in the appropriate s The RN will be notify. The RN will ensure the MARs and POS the onsite nurse after POS will be forward posted on the MAR. The onsite nurse after and the mass nurse of any c review all POS prior Discrepancies/abno to the attention of the clarification. 	e will contact the RN with a t and will file the consult form ection of the medical book. fied of all abnormal findings. all new orders are posted on all new orders are posted on all POS will be reviewed by er each appointment. The led to the pharmacy and /POS by the onsite nurse. will document in a progress d will inform the medication hanges. All nursing staff will to medication administration. rmal findings will be brought e RN and PCP for review and	W	000			
	administration. The staffing is not availal 7. The RN will obser	RN will be notified if proper					
-	racking/observation	ive a copy of all pertinent information with each visit. hitted at approximately 6:50 owing:					
1 ii s	I. The PCP was tele nsulin clarification. (stick prior to each me endocrinologist at las	phoned for finger stick and Current orders read finger eal and bedtime written by t appointment (8/30/11, eviewed and confirmed).					

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Facility ID: 09G153

If continuation sheet Page 3 of 33

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				D: 11/10/2011	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE S COMPL	SURVEY	
		09G153	B. WING		10/2	26/2011	
NAME OF	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COD			
СОМРО			1	29 LONGFELLOW STREET NW ASHINGTON, DC 20011		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	×.
W 000	reviewed with the P discharge of 2/2011 endocrinologist 8/20 read: finger stick pr bedtime. Sliding sca on finger stick resul stick. RN will fax ve review and signatur 2. The RN observed stick check at 5:47	he call at 5:45 p.m. The RN CP the orders from hospital I, follow-up visit 7/2011 and D11. New telephone order to ior to each meal and before ale to be administered based ts. If client eats hold finger rbal orders to PCP for his e. d <lpn #1=""> complete finger p.m.; results 115. No uptoms of hypo/hyperglycemia.</lpn>	W 000				· · ·
	 4. LPN #1 has been effective immediate nurse has been ass administration/treatu and insulin injection observed administe and insulin on the for 5. Telephone order medication orders s 	i removed from the schedule ly. Another medication pass igned medication ment (including Client #1's FS). [Note: LPN #2 was ring the client's finger stick ollowing morning.] (TO) posted and placed in ection of POS and posted on		·			
W 156	MAR. The TO was morning as follows: if individual eats and thereafter." 483.420(d)(4) STAF CLIENTS The results of all inv	further clarified the next "Hold finger stick for 2 hours I check blood glucose	W 156				

Facility ID: 09G153

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PRINTED: 11/10/2011

SINIEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULT		_	<u>. 0938-(</u>
		IDENTIFICATION NUMBER:	A. BUILDING		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(X3) DATE SURVEY COMPLETED	
		09G153	B. WIN	IG			
NAME OF	PROVIDER OR SUPPLIER					10/2	6/2011
COMP				1	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW VASHINGTON, DC 20011		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	- ID		PROVIDER'S PLAN OF CORRECTION		,
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E NTE	(X5) COMPLE DATE
W 156	Continued From pa	age 4	W 1	56	Wiec	——	<u> </u>
	or to other officials	in accordance with State law	•• •	с С	W156		
	within five working	days of the incident.			Comprehensive Care II Inc. wi	11	
				i	develop a Policy and Procedure	e	
	This STANDARD	s not met as evidenced by:		!	that addresses State reporting		
	Dased on starring	VIEW and record review, the		:	requirements. Said policy will		
	acility falled to ens	Ure all investigations wore			include names/position and	:	
	within the	le working dave of the instals of			contact information of all		
	sampled clients. (C	and safety, for one of two		ſ			
					Agency personnel to be notified		
	The finding includes	3 :			related to incident reporting as		
	Record review on O	intohon DE DOLL		- i	well as the results of any		
	approximately 10:10	a.m., revealed Client #1 was			investigation undertaken by		
	taken to the local ho	Spital on January 18, 2014			Agency staff. Said policy will		
	ion emergent care d	US IO Elevated blood alwages			also include appropriate and	-	
	197019 (070 mg/g) a	nd a swollen face. According t, the right side of Client #1's			required incident and		
	iace was swollen an	O DIS DIOOd sugar levels word			investigation completion time		
	Carcellar 0.00 p.m. F	UITNET record review			frames. All personnel, including		
	revealed the facility of	Completed their investigation			administrative ato a		
	into this incident on I	-ebruary 5, 2011.			administrative staff, will be in-		
	Interview with the fac	cility's qualified intellectual			serviced on above-reference		·
	usability protessiona	(QIDP) and house manager			policy and procedure, and a		•
	(1 M) On October 25.	2011 at annrovimately 2.00 i			Quality Assurance (QA)		.•
	p.m., confirmed the l	1Cident took place on		8	administrator will be tasked to		;
i	January 18, 2011, an nvestigation was con	d that the ensuing npleted on February 5, 2011.			ensure compliance.		
100 -	+03.430(a) QUALIFIE	D MENTAL	14/ 4 50	9	-	10	03.
F	RETARDATION PRO	FESSIONAL	W 159	: :			1001
E	Each client's active th	eatment program must be					
	ntegrated, coordinate ualified mental retard	and monitored by a				1	
4		auon professional.	1			:	

Event ID: L7MZ11

Facility ID: 09G153

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CENT	ERS FOR MEDICARE	AND HUMAN SERVICES				FOR	D: 11/10/201 M APPROVE
AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
L	·	09G153	B. WI	NG			
NAME OF	PROVIDER OR SUPPLIER			0.70		10/	26/2011
				1	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW VASHINGTON, DC 20011		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX ·	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRC	(X5) COMPLETION DATE
	This STANDARD is Based on interview failed to ensure that disabilities professio coordinated and mon the two clients in the The findings include: 1. On October 26, 20 with Client #2's day p revealed that on Octo became aggressive s morning. The client a After his one-to-one s return home, the facil the client home. Client program for the next of recommended by the a. Further interview m program had sought in staff from the resident program case manage of requests made to the Individual Support Pla 7, 2011, and another m September 29, 2011. declined her requests staff. On October 25, 2011, a a.m., review of Client # 2011, revealed the folk QMRP and supervisor ensuring that all who w are trained to implement	and record review, the facility and record review, the facility the qualified intellectual nal (QIDP) integrated, nitored services, for two of sample. (Clients #1 and #2) 11, at 11:30 a.m., interview program case manager ober 10, 2011, the client shortly after his arrival that attempted to hit someone. Staff recommended that he ity van returned and drove it #2 did not return to day two weeks, as psychiatrist. evealed that Client #2's day n-service training for their tial psychologist. The day er presented documentation the QIDP at the client's in (ISP) meeting held June equest made on	W 1		W159 (1a) Client #2's day program stat will be trained on November 2011 by the psychologist of the residential facility. Comprehensive Care will develop a Policy and Procedur related to Individual Service Coordination and Communication. This policy will outline the procedure for coordination and collaboration with day and other support program providers. The policy will also address training requirement, behavior data documentation, and protocols for interdisciplinary team communication to guarantee that each identified team member is notified and made aware of any incident, and request by other agencies that may require immediate intervention to ensure continue support of the client's/individual's care or service goals.	· 29, he ure r on cy s t t	2. 03.11

Facility ID: 09G153

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CENTE	ERS FOR MEDICARI	HAND HUMAN SERVICES			PRINTED: 11/10/20 FORM APPROV _OMB NO: 0938-03	
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_		09G153	B. WINC	3		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		10/26/2011	
COMPC	CARE		ĺ	STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT		
F b b tr C	 billowing: "Support staff" while at the da When the QIDP wat 2011, at 3:50 p.m., I day program had reat their staff. He stated resides in an ICF/ID responsible for develobehavior support plat staff. b. During the interviewer behavior support plat staff. b. During the interviewer extremely wat and the staff. b. During the interviewer extremely wat and the staff. On October 24, 2011 Client #2's BSP reveat the staff. Con October 24, 2011 Client #2's BSP reveat the staff. Con October 24, 2011 Client #2's BSP reveat the staff. Con October 24, 2011 Client *2's BSP reveat the staff. Con October 24, 2011 Client's name> and the staff. Con october 26, 2011, and the staff. Con October 26, 2011, and the staff. 	ne 7, 2011, revealed the provided by day program by program. It is interviewed on October 26, ne confirmed that Client #2's quested in-service training for d that because Client #2 the day program was loping and implementing a n (BSP) and training their ew with Client #2's day ger on October 26, 2011, at d that the client could iolent" and his one-to-one ensure his safety and that at 2:15 p.m., review of ensure his safety and that aff should use only the least ention procedures approved o secure the safety of hat of others." d staff in-service training d on October 25, 2011, . There were certifications iting that Staff #1 and #2, signed to work with Client had received said training b, however, indicated the	W 15	9 W159 (1b) Client #2's staff (Staff #1 an have been scheduled to atten refresher course on Crises Prevention and Intervention (CPI) techniques on Decemb 2011 and December 12, 2011 Other facility staff will recei such training on the above- mentioned days. The administrative assistant consonance with the QIDP w on a monthly basis review al personnel records to ensure training records and other certification requirements an updated timely.	nd a per 9, l. ve 12.09.1(12.12.1] in vill 1 that	

Facility ID: 09G153

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			<u>OMB NO. 0</u>	938-03
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURY COMPLETE	VEY
	09G153	B. WING			
NAME OF PROVIDER OR SUPPLIER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW	10/26/2	2011
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES		ASHINGTON, DC 20011		
	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		(X5) OMPLETIC DATE
W 159 Continued From pag was aware of the tra	ining need and she stated	W 159	W159, 2 Comprehensive Care wi		
that OFT training nat	not yet been scheduled.		develop a Policy and Pro	cedure	
that all staff who would that all staff who would on the client's behave	nce that the QIDP ensured rk with Client #2 were trained		related to Individual Ser Coordination and		
2. On October 24, 2	011 Client #2 was		Communication. This period will outline the procedur	e for	
administered Depake Haloperidol at 8:12 a medical chart on Oct revealed a lab report	ote, Risperdal, Cogentin and .m. Review of the client's tober 24, 2011, at 3:45 p.m., dated February 15, 2011		coordination and collabo with Interdisciplinary Te (IDT) and other support program providers.	ration am	
[Note: Other lab repo [Note: Other lab repo May 19, 2011, did no On October 25, 2011 client's psychiatric red that the prescribing p	serum prolactin level of ce range 2.5 - 17.0 ng/ml). rts dated May 24, 2010 and t reflect prolactin testing.] , at 11:50 a.m., review of the cords revealed no evidence sychiatrist and others		The policy will address ti notification of IDT with emphasis to notifying the psychiatrist of abnormal	ab	
Medication Review te	ient's Psychotropic am were made aware of the /el reading from February		values and/or recommend from other members of th support team.	e e	
should see all of the p p.m., the RN examine records, including the	at 12:41 p.m., the facility's stated "the psychiatrist erson's labs." At 12:46 d Client #2's psychiatric Psychotropic Medication nfirmed the aforementioned		Once monthly, the facility QIDP and RN will review medical records to ensure abnormal lab values and recommendations from co are communicated to the psychiatrist and other men	ali that nsults	
There was no evidence that Client #2's prescri aware of serum lab tes 2011, showing elevated	e that the QIDP ensured bing psychiatrist was made sts, dated February 15, d prolactin levels.		of the support team for all clients being supported.	12.()3.][
3. The QIDP failed to	ensure that Client #1's				

FOR M CMS-2567(02-99) Previous Versions Obsolete

Event ID: L7MZ11

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Facility ID: 09G153

If continuation sheet Page 8 of 33.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	///			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	09G153	B. WING			
NAME OF PROVIDER OR SUPPLIER				10/26	2011
COMP CARE I I		· · ·	REET ADDRESS, CITY, STATE, ZIP COD 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	Æ	
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES	<u>I</u> D			
TAG REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOLILD BE	(X5) COMPLET DATE
W 159 Continued From pa	ge 8	N/ 150			<u> </u>
Individual Program	Plan (IPP) included training	W 159	W159, 3	<u> </u>	
	De Client's needs as		Please see W 227		
recommended by th	e interdisciplinary team. [See				
W227]			W159, 4		
4. The OIDP failed	to ensure clients received	i	Please see W 249		
continuous active tre	eatment. [See W249]		W159, 5		
	-		Please see W 252		
5. The QIDP failed	to ensure behavior data was	1			
documented in acco	rdance with the behavior				
Support plan (BSP).	[See W252]			:	
W 227 483.440(c)(4) INDIV	IDUAL PROGRAM PLAN	W 227		а. С	
The individual progra	am plan states the specific				
objectives necessary	to meet the client's needs				
as identified by the c	Omprehensive assessment				
required by paragrap	h (c)(3) of this section.				
Based on observatio	not met as evidenced by: n, interview and record	1		1	
review, the facility fail	ed to ensure that the	:		ſ	
mulvioual Program Pl	an (IPP) included objectives	1			
	200S 2S recommended by	!			
the interdisciplinary te	am, for one of the two				
clients in the sample.	(Client #1)	:		· 	
The finding includes:				1	
On October 25, 2014	at 11:50 a m. Olive t #4	1			
arrived home from a r	at 11:50 a.m., Client #1 loctor's appointment. The	i t			
direct care staff was o	bserved placing the client in	-		i	
a chair in the living roo	DM. The staff was observed	i i		. •	
retrieving the remote c	control and turning on the				
tate to the territore (
leievision. The staff w	as further observed using				
the television remote of	ras further observed using control, flipping through the client if the station was				

Facility ID: 09G153

If continuation sheet Page 9 of 33

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TATEME	ENT OF DEFICIENCIES	E & MEDICAID SERVICES			OMB NO. 0938-(
ND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G153	B. WING			
	PROVIDER OR SUPPLIER				<u> 10/26/2011 </u>	
COMP	CAREII			TREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID		ATEMENT OF DEFICIENCIES				
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE CONPLET	
W 227	7 Continued From pa					
	"okay." Once a ch	annel was pleasing to the client	W 227	W227		
	he responded by m	noving his head in an up and				
	down motion.	in an up and		A training goal for the use of	fa	
				television remote control by		
	Review of Client #1	's psychology assessment		client #1 has been put in plac	:e.	
	10:31 a m reveale	, on October 26, 2011, at		All Direct Support Staff (DS	S)	
	develop a program	d a recommendation to for him to learn how to use a		and the House Manager (HM	I) :	
	remote control devi	ce to turn the television on/off		have been trained on the		
	while in a seated po	sition,		implementation of client #1's		
		í		remote control program.		
	Review of the IPP of	lated June 7, 2011, on				
	October 26, 2011, a	at approximately 11:30 a.m.,		On a monthly basis, the facili	tv's	
	address the aforom	ce of a training program to		QIDP and RN will review		
	the psychologist	entioned recommendation by		habilitation records of all the		
	and poyonologist.			clients to ensure that		
	Interview with the au	alified intellectual disabilities		recommendations are adhered	d to	
	professional (QIDP) p.m., revealed that h	on October 26, 2011, at 4:15	-	as specified.		
	recommended traini	ng objective and therefore no		Quartorly Andia		
240	u anning program nac	Deen developed	ĺ	Quarterly Audit will be done	by	
249	483.440(d)(1) PROC	GRAM IMPLEMENTATION	W 249	the quality assurance person t	:0	
	As soon as the inter	dinain linear teasta t		ensure that all recommendation		
	As soon as the interc formulated a client's	individual program plan,		are implemented as specified.	11.01.11	
	each client must rece	eive a continuous active				
	treatment program c	onsisting of needed	l			
	interventions and ser	VICES in sufficient number	:			
	and frequency to sup	port the achievement of the	:		1	
	objectives identified i plan.	n the individual program				
	• •					
	This STANDARD is Based on observatio	not met as evidenced by: n, staff interview and record				

FOR ns Obsolete

IATEMEN	IT OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		09G153	B. WING			
COMP C	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	<u> </u>)/26/2011
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	(H D RE	(X5) COMPLET DATE
W 249	received continuous	active treatment, for one of sample. (Client #1)	W 249			
t e t e t e t e t e t e t s T w s CCd (a	a.m. until 8:55 a.m., chair at the dining ro client was observed and going to day pro home from day prog observed until 5:40 p received personal hy to the living room. W room, he was observ an ottoman and had remained seated. At observed assisting th for dinner. On Octob until 2:00 p.m., Client the living room watch elevated. n an interview on Oct approximately 2:05 p. client stayed home from the staff further stated wheelchair "all" the tim tanding program.	te client to the dining room er 25, 2011, from 12:05 p.m. #1 was observed sitting in ing television with his feet tober 25, 2011, at m., staff indicated that the om day program two days tiry was made to the staff, client was getting "stronger" to the hospital in May 2011. d the client did not use the me and he participated in a at 10:00 a.m., review of erapy (PT) assessment evealed a recommendation pted by the interdisciplinary		W249 All Direct Support Staff an residential House Manger & been trained on implements of Individual Program Plan (IPPs) of all residents. Once weekly, the facility's (and House Manager will ob staff during implementation IPPs to ensure that all progr plans are implemented as outlined. Comprehensive Care will institute, beginning December 2011, monthly meetings betw LPN, RN, QIDP, and residen management staff to discuss, among other agenda items, th implementation of IPPs by st	ation ation s QIDP serve of ram er, veen ntial he	1.02.11

Facility ID: 09G153

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STATEM	ENT OF DEFICIENCIES	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MU A. BUILE	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G153	B. WING		
NAME O	F PROVIDER OR SUPPLIER				10/26/2011
COMP	CAREII			TREET ADDRESS, CITY, STATE, ZIP COD 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	E
(X4) IC PREFI) TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	
W 24	stand at least three awake." Minutes la program plan (IPP)	e minutes every hour that he is ater, review of the individual dated June 7, 2011, revealed	W 24		
	stand with physical minutes every hour months at 100% ac	e which stated "[the client] will assistance for at least 2 that he is awake for three curacy." Review of the client's			
	10:35 a.m., reveale	ber 26, 2011, at approximately d that the staff had not mance data for that program			
	assigned to Client # 24, 2011, she confir participate in the sta morning of October 2011. Staff, however	1, at 9:00 a.m., in an rect support staff who was 1 on the morning of October med that the client did not ending program on the 24, 2011 and October 25, er, had not been observed ogram on October 24, 2011			
	with his IPP.	pate in his standing program aking hours, in accordance			
252	483.440(e)(1) PROG	RAM DOCUMENTATION	W 252		
	specified in client ind	mplishment of the criteria ividual program plan ocumented in measurable			
	This STANDARD is a Based on interview a staff failed to docume	not met as evidenced by: nd record review, facility nt behavior data in			

Facility ID: 09G153

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FOF	ED: 11/10/201
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION	(X3) DATE	10. 0938-039 E SURVEY PLETED
		09G153	B. WIN	G		
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>			/26/2011
COMP C				STREET ADDRESS, CITY, STATE, ZIP CC 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	DE	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETION DATE
W 252	Continued From pa accordance with the for one of the two cl #2) The finding includes	e behavior support plan (BSP), ients in the sample. (Client	W 2	52	,	
(((((((((((((((((((On October 24, 201 with Client #2's day revealed that on Oct experienced a behave arrival at day program threatened to hit a pur reportedly intervened contact. Further inter revealed the 1:1 staff her office and inform well. The residential thereafter and took he subsequently stayed the next two weeks. Interviews with Client qualified intellectual of (QIDP) [October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at confirmed the client we morning of October 1 behavioral incident ar Dn October 25, 2011, at commented on the da very shift" At 11:05	1, at 11:40 a.m., interview program case manager ober 10, 2011, the client vioral incident shortly after his m. The client reportedly eer. Client #2's 1:1 staff 1 and prevented any physical review with the case manager f then brought the client to ed her that the client was not van returned shortly im home. Client #2 home from day program for #2's 1:1 staff and the lisabilities professional 2011, at 4:00 p.m., and 3:50 p.m., respectively] vas brought home on the 0, 2011, due to his ind mental status. beginning at approximately client #2's BSP, dated June ysical aggression" was one ptive behaviors and "all behavior should be ata sheet provided on 0 a.m., review of the consequences (ABC) form		W252 Client #2's day program residential staff will be on Client #2's BSP and data collection. Empha- placed on accurate and consistent data reportin The facility's House Ma will on a weekly basis m staff in implementing th interventions specified i #2's BSP and accurate of collection.	trained behavior sis will be ng. nager ionitor ne in Client	11-24-11

FOF 7(02-99) Previous Versions Obsolete

Event ID: L7MZ11

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CENTERS FOR MEDICAR	TH AND HUMAN SERVICES				FOR	D: 11/10/2011 MAPPROVED 0.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP LDING		(X3) DATE SURVEY COMPLETED		
	09G153	B. WI	IG	·····		·····	
NAME OF PROVIDER OR SUPPLIER			STDE		10/	26/2011	
COMP CARE II			132	ET ADDRESS, CITY, STATE, ZIP CODE 29 Longfellow Street NW ASHINGTON, DC 20011			
PREFIX (EACH DEFICIEN(ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	LILD BE	(X5) COMPLETION DATE	
V 318 483.460 HEALTH C	nything and everything that int; what was said and done by o the situation; whether the lved and if so how long it took." of the ABC form revealed the ed Client #2 arrived at day o shake a peer's hand "and r consequence, the staff wrote: topped <client's name=""> from was no evidence the staff thing that followed the (i.e. the returned home that lance with the BSP. CARE SERVICES</client's>	W 2					
Based on observation record review, the fact diabetes in accordan [See W322]; ensure obtained as recomm [See W326]; provide services in accordan W331]; ensure quart status [See W336]; ensure training on signs and hyper/hypoglycemia recommended to ensure [See W342]; ensure were conducted at lea ensure that all prescu administered in accord	s not met as evidenced by: ions, staff interviews and acility failed to: manage ince with physician's orders laboratory studies were hended by an endocrinologist e each client with nursing nce with their needs [See terly review of client's health ensure all staff received d symptoms of and shortness of breath as sure client health and safety that drug regimen reviews east quarterly [See W362]; ribed medications were rdance with clients' physician ensure clients received		a na a manananan a anna a an anna anna				

FOR 9) Previous Versions Obsolete

Event ID: L7MZ11

Facility ID: 09G153

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F HEALTH	AND HUMAN SERVICES				D: 11/10/2011
IEDICARE					M APPROVED. <u>D. 0938-03</u> 91.
INCIES ION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	
	09G153	B. WING			
SUPPLIER					26/2011
			1329 LONGFELLOW STREET NW		
DEFICIENCY	MUST RE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	IOULD BE	(X5) COMPLETION DATE
d From nar	ne 1/				
ns without lications ur See W381] ts of these	error [See W369]; and to ider proper conditions of systemic practices resulted	W 318	W318 Please see W322, W326,	W331, 68,	
]				
		W 322			
y must prov edical care	vide or obtain preventive and		· · ·		
observatio iew, the fac opardy by nce with pl diabetes or	n, staff interviews, and sility placed client health and failing to manage diabetes invsician's orders, for the one			1	
js include:					
ose finger s	ticks in accordance with his				,
ne facility to stated that Client #1 w wearing a ff revealed eakfast and nurse's arr dication nu	o initiate the survey. Clients they had already eaten their /as seated at the dining bib. Interview with a direct that all four clients had were now awaiting the ival. She further indicated rse typically arrived				
	AEDICARE INCIES	IDENTIFICATION NUMBER: 09G153 R SUPPLIER UMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) d From page 14 ons without error [See W369]; and to dications under proper conditions of See W381]. ts of these systemic practices resulted ure of the facility to provide health care 0(3) PHYSICIAN SERVICES y must provide or obtain preventive and edical care. NDARD is not met as evidenced by: observation, staff interviews, and iew, the facility placed client health and eopardy by failing to manage diabetes nce with physician's orders, for the one diabetes out of a two-client sample.	MEDICARE & MEDICAID SERVICES INCLES (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: (X2) MUL A. BUILD 09G153 B. WING R SUPPLIER S JIMMARY STATEMENT OF DEFICIENCIES IDEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG d From page 14 ons without error [See W369]; and to dications under proper conditions of See W381]. W 318 ts of these systemic practices resulted ure of the facility to provide health care W 322 v)(3) PHYSICIAN SERVICES y must provide or obtain preventive and edical care. W 322 VDARD is not met as evidenced by: observation, staff interviews, and iew, the facility placed client health and eopardy by failing to manage diabetes nore with physician's orders, for the one diabetes out of a two-client sample. gs include: Ify failed to ensure Client #1 received ose finger sticks in accordance with his order sheets (POS), as follows: r 24, 2011, at 7:40 a.m., the surveyors ne facility to initiate the survey. Clients stated that they had already eaten their Client #1 was seated at the dining wearing a bib. Interview with a direct ff revealed that all four clients had eakfast and were now awaiting the nurse's arrival. She further indicated dication nurse typically arrived	MEDICARE & MEDICAID SERVICES INDEX (X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER (X2) MULTIFILE CONSTRUCTION A BUILDING 09G153 B WING 09G153 STREET ADDRESS, CITY, STATE, ZIP CODE 1328 LONGFELLOW STREET NW WASHINGTON, DC 20011 IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS FLAN OF CORR CROSS-REFERENCED TO THE AP DEFICIENCY d From page 14 ins without error [See W369]; and to dications under proper conditions of See W381]. W 318 W336, W342, W362, W3 W369, and W 381. W318 VW 309, and W 381. W369, and W 381. ir of these systemic practices resulted ure of the facility to provide health care b)(3) PHYSICIAN SERVICES W 322 VM MARY is not met as evidenced by: observation, staff interviews, and edical care. W 322 VDARD is not met as evidenced by: observation, staff interviews, and ew, the facility placed client health and evorth physician's orders, for the one diabetes out of a two-client sample. is include: Ity failed to ensure Client #1 received is finger sticks in accordance with his order sheets (POS), as follows: r 24, 2011, at 7:40 a.m., the surveyors tated that they had already eaten their Client #1 was seated at the dining wearing a bib. Intriview with a direct frevealed that at lef our clients had takfast and were now awaiting the nurse's arrival. She further indicated dication nurse typicality arrived	HEDICARE & MEDICAID SERVICES OMB XN INCLES (X1) PROVIDERSUPPLERUCIA (DENTIFICATION NUMBER: DENTIFICATION NUMBER: 09G153 (X2) MULTIFILE CONSTRUCTION A BUILDING (X3) DATE COMP INCLES 09G153 STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGPELLOW STREET NW WASHINGTON, DC 20011 10/ 10/ 12ACOMP IMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) IP REPX TAG PREPX (FACH CORRECTION ACTION ADDRESS (CROSS-REFERENCED to THE ADDRESS) (CROSS-REFERENCED TO THE ADDRESS (CROSS-REFERENCED TO THE ADDRESS (CROSS-R

Event ID: L7MZ11

Facility ID: 09G153

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ALEMEN		E & MEDICAID SERVICES	(X2) MILL T		FORM APPRO MB NO. 0938-	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	W	(X3) DATE SURVEY COMPLETED	
		09G153	B. WING			
AME OF	PROVIDER OR SUPPLIER				10/26/2011	
OMP C	CAREII		1	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW		
				VASHINGTON, DC 20011		
X4) ID REFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
/ 322	Continued From pa	ne 15				
	in a second pu	ge 10	W 322	W322, 1		
	A licensed practical	nurse #1 (LPN #1) arrived at		The nurse in question has bee	n l	
	o. IV a.m. and bega	n preparing the clients'	ļ	relieved of his duties with		
	medications at 8:12	a.m. When I PN #1 wont into 1		Comprehensive Care II, Inc.		
	intellectual disabilitie	a, at 8:46 a.m., the qualified es professional (QIDP)				
	informed him that th	e four clients had left the		The facility's RN will ensure	1	
	Tacility for their day a	programs The yap refurned	1	that all nursing and direct		
	to the facility at 8:59	a.m. and I PN #1		support staff are trained in		
	9:00 a m The L DN	#1's medications by mouth at	ļ	diabetic management/care to		
	QUCOSE finger stick	then performed a blood (reading was 346) after which		include individual-specific		
	he administered 6 u	nits of Novolog into the	r i	training, medication		
	client's right arm.			management,		
	0 0 1 1		i	Physician /RN notification,		
	On October 24, 2011	I, at 11:11 a.m., review of		documentation, and diabetic		
	October 2011, revea	he period May 4, 2011-		protocol as specified on		
	insulin-dependent di	abetes mellitus for which he		Client#1's Physician Order		
	nau the following ord	ers: "Novolog 1000//Mi		Sheet (POS). Emphasis of the		
	inject 5 units subcuta	neously with each meal for		training will be administration		
(Javeles and "Check	(finger stick at mealtimee		of insulin at every meal as		
	200-250: 1 unit of No	ng scale as follows: volog: 250-300: 4 units of		specified on Client#1's POS.		
· •	vovolog; 301-350: 6	Units of Novolog: and within	i i	The OIDD will an a man did		
	350 and 400: 8 units	of Novolog."		The QIDP will on a monthly		
C	DI October 24 2044	0144-25		basis conduct oversight of		
· fi	ace interview with 1	at 11:35 a.m., in a face to N #1, he indicated that staff		medication administration to		
- - -	au been iniormed th	at it the medication nurse		ensure that nursing staff are	1	
- V	as late, they should	"still" wait before feeding		adhering to physician's orders.		
L	ment #1. He further:	stated that he usually		The DN/Dimenter Cov		
B M	(as running late that	t 7:30 a.m.; however, he		The RN/Director of Nursing wi		
	ac ronning late (flat l	morning (October 24, 2011).		maintain direct oversight for the	ie	
	. The facility failed to	ensure Client #1 received 5		delivery of nursing services by licensed practical nursing staff.	11.30.11	
_ _		y meal, in accordance with				

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		(X1) PROVIDER/SUPPLIER/CLIA	(72) 6414	0	MB NC	APPRO
IND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SURVEY COMPLETED	
		09G153	B. WING			
NAME OF	PROVIDER OR SUPPLIER				10/2	26/2011
COMP C				REET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u>_</u>			
TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE	(X5) COMPLETI DATE
W 322	Continued From pa	age 16	W 322		<u> </u>	<u>├</u>
				W322, 2]	
	inject 5 units suba	cluded: "Novolog 100U/ML,		The nurse in question has been	n	-
	diabetes" and "Che	itaneously with each meal for eck finger stick at mealtimes		relieved of his duties with		i
	and cover with a si	Iding scale as follows:		Comprehensive Care II, Inc.		
	200-200: 1 unit of M	Novolog: 250-300 A upite of				
	110v0l0g, 301-350	6 Units of Novolog: and within 1		The facility's RN will ensure		
!	330 anu 400; 8 uni	IS Of NOVOLOG " As noted	1	that all nursing and direct		
	Novolog prior to ear	as not administered 5 units of ting breakfast on October 24,		support staff are trained in	'	
	2011.	ung breaklast on October 24,	[diabetic management/care to		
			Ì	include individual-specific		
	When interviewed of	on October 24, 2011, at 11:35		training, medication		
	a.m., LEIN #1 Stated	I That the facility's purpose head		management,		
	not been auminister	100 NOVOlog 5 units at		Physician /RN notification,		
· (Client #1's POS rev	N interview and review of ealed the client had been		documentation, and adhering to		
1	readmitted to the fac	cility with those orders on May		diabetic protocol as specified of	0	
-	T, ZUTT, aner an ext	ended hospital stay In		Client#1's Physician's Order		
č	audition, on October	24, 2011, at 11:40 a.m.		Sheet (POS). Emphasis of the		
1	eview of Client #1's	Medication administration	[training will be administed the		
ti ti	brough October 22	he period May 24, 2011		training will be administration		
ť	hat the client had re	2011, revealed no evidence ceived Novolog 5 units with		of insulin as specified on Client#1's POS.		_
e	every meal.	ceived Novolog 5 units with	L	Chentiff S FUS.		1.30.1
3	. The facility failed t	o provide oversight of				
b	eing implemented, a	nsure Client #1's POS were as follows:				
A	s already indicated	above, Client #1 and his	F.			
m	eers ate breakfast b redication nurse arri	ved at 8:10 a.m. The				
CI	ient's blood alucose	level was not checked prior i				
10	preaktast and he w	/as not administered 5 unite			÷	
0	insulin at meal time	e. as ordered by the	i i			:
pr	iysician. The LPN a	acknowledged that the client ve 5 units of insulin with				

Facility ID: 09G153

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE FOF	ED: 11/10/2011 RM APPROVED
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			O. 0938-0391 SURVEY PLETED
	09G153	B. WI	NG			
NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	10	/26/2011
COMP CARE II			13	ASHINGTON, DC 20011		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG	IX I	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETION DATE
W 322 Continued From page		W 3	322	W 322, 3		
every meal, and revie supported the LPN's Review of Client #1's 25, 2011, at approxim Diabetic Clinic consul 2011 that reflected the fasting sugar readings to his insulin at this tim enough pre-meal bloo should return in 2-4 w fasting sugar levels be suggest any needed of care physician (PCP) form on September 2, Interview with the QID 11:50 a.m., revealed the that Client #1 received each meal and then ad accordance with the sl above. There was no had been monitoring C blood glucose testing a insulin by the nursing the On October 25, 2011, a nurse (RN) verified and POS read as written ab that best nursing practic glucose finger sticks be	w of Client #1's MARs statement. medical record on October nately 1:05 p.m., revealed a t form dated August 30, e following: "not enough s no changes will be made ne because there was not ed glucose reading. Patient eeks with a log of his efore each meal and I will hanges" The primary had initialed the consult 2011. P on October 24, 2011, at nat it was his understanding 5 units of Novolog with iditional insulin in iding scale, as written evidence that the QIDP client #1's meal times, and/or the administration of eam. at 1:04 p.m., the registered I confirmed that Client #1's pove. She further stated ces would indicate blood e done up to one hour prior	W		W322, 3 The nurse in question has b relieved of his duties with Comprehensive Care II, Ind The facility's RN will ensure that all nursing and direct support staff are trained in diabetic management/care to include individual-specific training, medication management, Physician /RN notification, documentation, and diabetic protocol as specified on Client#1's Physician Order Sheets (POS). Emphasis of th training will be administratio of insulin at every meal as specified on Client#1's POS. The QIDP will on a monthly basis conduct oversight of medication administration to ensure that nursing staff are adhering to physician's order	e o	
glucose testing and/or t insulin by the team of m Review of Client #1's bl	o evidence that an RN had #1's meal times, blood the administration of nedication nurses/LPNs. ood glucose finger sticks period May 2011 through		C	The RN/Director of Nursing v naintain direct oversight for lelivery of nursing services by icensed practical nursing stat	the y	11.30.11

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STATEME	NT OF DEFICIENCIES	E & MEDICAID SERVICES	(12) 14	ULTIPLE CONSTRUCTION		<u>). 0938-039</u>
ANU PLAI	NOF CORRECTION	IDENTIFICATION NUMBER:		LDING	(X3) DATE COMPL	
		09G153	B. WIN	IG		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		26/2011
		·		1329 LONGFELLOW S WASHINGTON, DC	TREET NW	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
W 322	2 Continued From pa	age 18	W 3	22	·	<u> </u>
	October 2011, on (October 25, 2011, at 11:31	VV 3	22		
	a.m., revealed that	the nursing staff were				
	accumenting blood	QUCOSE finder sticks three				
	umes per day (7:0(a.m., 1:00 p.m., and 8:00				i 1
	staff however bad	th LPN #1 and direct support revealed that the LPN had				1
	been arriving between	een 7:30 a.m. and 8:00 a.m. In				
	addition, LPN #1 st	ated that nursing staff had not				.
	been conducting bi	000 QIUCOSE finder sticks at				
	equime, even thou	gh it had been recommended				
	by the endocrinolog	list on August 30, 2011 and				
	signed-on by the P	CP on September 2, 2011 On				
	- October 25, 2011, a	at approximately 1.20 n m the L		:	I	
	diucose finger stick	t # 1's October 2011 blood		1 :		
	did not represent th	chart and stated the entries e exact times the LPNs had			1	
	administered the fin	der sticks.				
		-		1		
	It should be noted the	nat surveyors remained onsite			ſ	
	removing the immediate	systems in place, thereby,				
W 326	removing the immed	liate jeopardy.				
	400(a)(3)(iii) PF	IYSICIAN SERVICES	W 32	6		
	The facility must pro	vide or obtain annual physical				
:	examinations of eac	h client that at a minimum				
	includes special stud	dies when needed				
				[ļ	
	This of the					
	This STANDARD is	not met as evidenced by:				
	Based on observation	on, staff interview, and record				
	studios were abteine	iled to ensure laboratory				
	endocrinologiet for a	d as recommended by an		Ì		
:	sample. (Client #2)	one of the two clients in the				
	The finding includes:				· · · · · · · · · · · · · · · · · · ·	
	J			1	i	4
	-	nedication administration, on				

Facility ID: 09G153

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NAME OF PROVIDER OR SUF COMP CARE II (X4) ID PREFIX TAG REGULATOF W 326 Continued Fre	OPCLIER ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) OM page 19	A. BUILD B. WING	DING DING DING DING DING DING DING DING	
COMP CARE II (X4) ID SUMMA PREFIX (EACH DEF TAG REGULATOR W 326 Continued Fre	PPLIER ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) OM page 19	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	
COMP CARE II (X4) ID SUMMA PREFIX (EACH DEF TAG REGULATOR W 326 Continued Fre	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) OM page 19	ID PREFIX	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	
(X4) ID SUMMA PREFIX (EACH DEF TAG REGULATOF W 326 Continued Fro	OTENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	
W 326 Continued Fro	OTENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	
W 326 Continued Fro	om page 19	1		NATE ONTE
On October 24 Client #1's Oc (POS) confirm of diabetes me review of the o diabetic clinic of August 30, 20 the client recei studies. Furth that the primar initialed and da September 2, 2 dated Septemb	2011, at 9:00 a.m., Client #1 was eiving a blood glucose fingerstick. The licensed practical nurse (LPN medication administration revealed had a diagnosis of diabetes. 4, 2011, at 11:11 a.m., review of the tober 2011, physician's orders hed that the client had a diagnosis ellitus, insulin dependent. Further client's medical record revealed a (endocrinology) consult dated 11. The consult recommended that ive HGAIC and anemia laboratory er review of the consult indicated by care physician (PCP) had ated the consult sheet on 2011. Review of laboratory studies ber 12, 2011, revealed no evidence mentioned studies were obtained on	W 32	6 W326 The RN will ensure all medical/lab appointments an physical exams are scheduled and completed. Consult order will be forwarded to the Prin Care Physician (PCP) for review. All verbal orders will forwarded to the PCP for reviewing /signature within 2 hours or the next business da The RN will on a weekly basis review all medical consults to ensure that all recommendati and/or follow-ups are adhered in a timely fashion.	d ers nary II be 4 y. s
Uctober 26, 20 revealed that w August 30, 201 agreement with The RN confirm laboratory studi recommended. W 331 483.460(c) NUF The facility mus services in acco	he registered nurse (RN) on 11, at approximately 4:00 p.m., then the PCP signed and dated the 1 medical consult sheet, he was in the specialist's recommendation. the specialist's recommendation. the HGAIC and anemia tes were not obtained as RSING SERVICES at provide clients with nursing brdance with their needs. D is not met as evidenced by: rvation, staff interviews and	W 331		

FOR ous Versions Obsolete

Facility ID: 09G153

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ND PLAN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		09G153	B. WING				
AME OF	PROVIDER OR SUPPLIER		_!			10/:	26/2011
	CAREII			13	EET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	NULD BE	(X5) COMPLETIO DATE
W 331	client with nursing s	facility failed to provide each services in accordance with r of the four clients residing in	W 3	31			
	sticks and received	e: sing services failed to ensure sived blood glucose finger insulin at every meal, in physician's orders. [See			W331, 1 Please refer to W 322 W331, 2 Please refer to W 326 W331, 3		•
	anoratory studies w	sing services failed to ensure ere obtained as n endocrinologist. [See			Please refer to W 336 W331, 4 Please refer to W 342 W331, 5		
	 The facility's nurs quarterly review of c W336] 	ing services failed to ensure lient health status. [See			Please refer to W 362 W331, 6 Please refer to W 368		· .
i c r	of hyper/hypoglycem	ing services failed to ensure ning on signs and symptoms ia and shortness of breath as sure client health and safety.			W331, 7 Please refer to W 369 W331, 8 Please refer to W 381		
T	5. The facility's nursi hat drug regimen rev east quarterly. [See	ing services failed to ensure views were conducted at W362]				 	•
ir	nal all prescribed me	ng services failed to ensure edications were administered ients' physician orders. [See					•
: 7	The facility's pursi	ng services failed to ensure				:	

FOF

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DEPAR		AND HUMAN SERVICES			PRINT	ED: 11/10/2011 RM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	OMB ((X3) DAT	NO. 0938-0391 TE SURVEY MPLETED
NAME OF		09G153	B. WIN	IG	1	0/26/2011
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP	SHOULD BE	(X5) COMPLETION DATE
W 331	Continued From pag clients received med W369]	ge 21 dications without error. [See	W 3	31		
W 336	Medications under p [See W381] 483.460(c)(3)(iii) NU Nursing services mu certified as not need review of their health	sing staff failed to store proper conditions of security. IRSING SERVICES ist include, for those clients ing a medical care plan, a in status which must be on a quent basis depending on	W 3:	W336 The quarterly report ha completed. A calendar h put in place to track wh nursing quarterlies are o	as been en	11.JD.11
	Based on staff interv facility's nursing serv	ient health status, for one of		On a quarterly basis, the Assurance (QA) person audit all habilitation rec ensure that reports are of filed in a timely manner.	will ords to lone and	
	2011, at approximate intellectual disabilities revealed that Client # from January 18, 201 Upon his return to the assessed by the inter- On October 24, 2011, review of Client #1's n nursing assessment d record review revealed nursing review in since egistered nurse on O	conference on October 24, ly 10:30 a.m., the qualified s professional (QIDP) 1 had been hospitalized 1 through May 4, 2011. a facility, the client had been disciplinary team (IDT). beginning at 11:15 a.m., nedical chart revealed a lated June 6, 2011. Further d no evidence of a quarterly e then. Interview with the ctober 25, 2011, at 1:04 he quarterly assessment		The Director of Nursing will review all nursing assessments for complete accuracy, and timely sub	eness,	

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D PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
			A. BUI		COM	PLETED
		09G153	B. WIN	G	40	00000
ame of	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	10	/26/2011
OMP C				1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	E	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	 a	PROVIDER'S PLAN OF CORF		
TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULDEE	(X5) COMPLETIO DATE
N 336	Continued From pa	ine 22			<u> </u>	
	had not been comp		W 3	36		i
N 342	483 460(c)(5)(iii) N					
		URSING SERVICES	W 34	l2		
	Nursing services m	ust include implementing with		W342, 1		-
	other members of t	he interdisciplinary team,		All staff have been traine	d on	
	appropriate protect	ive and preventive health	•	signs and symptoms of		
	measures that inclu	de, but are not limited to		hypo/hyperglycemia.		ļ
:	u anning direct care :	Staff in detecting signs and		JI - JF 8-J		
	symptoms of liness	Of dvsfunction first aid for		The opposite to an interest of the opposite		
	accidents or liness,	and basic skills required to		The oversight supervisor	Y KN	
	meet the health needs of the clients.			and the Agency's Directo	r of	
				Nursing (DON) will deve	op	1
	The opening			scheduled time frames for	r the	r 1.
	I INS STANDARD is	not met as evidenced by:		quarterly reviews of clien	t	j∉ k i
i i	based on start inter	VIEW and record review the		health status and each cli	ant's	
	acility failed to ensu	re all staff received training				
1	on signs and sympto	MS of hyper/hypoglycemia		medication regimen. In-s	ervice	1
: .	and shortness of bre	eath as recommended to		training modules will be		
1	clients in the second	and safety, for one of two		developed by the Agency'	s DON	
1	clients in the sample	. (Client #1)		for both LPN and DSP sta	ffon	
-	The findings include:			signs and symptom of con and specific illnesses/medi	mon	
• •	1. Record review on	October 25, 2011, at		conditions including short	ness of	
a	approximately 10:10	a.m. revealed Client #1 was		breath (SOR)	ncəş 01	
٠t	aken to the local hos	spital on January 18, 2011,		breath (SOB), sexuality,		
f	or emergent care du	e to elevated blood glucose		nutrition, communication	s, and	
.]	evels (375 mg/dl) an	d a swollen face. Further		assistive devices, emergen	y I	
r	ecold review on the	same day, at approximately		procedures, disaster plans	and	
· · ·	0.40 a.m., revealed	the ensuing investigation		fire evacuation procedures	All	
u	aleo repruary 5, 20	11. recommended that all		direct care staff will be rec		
;	stan be trained on si	QDS and symptoms of		to maintain current basic		
h	ypo/hyperglycemia b	y February 18, 2011."		Aid and CPR certification.		11 5.
Δ	review of the facility			L and CI N UI INCHION		11.30.11
	n October 05, 0044	's in-service training records				
` ^						
Q	vealed there was as	at approximately 2:00 p.m., evidence that the staff				

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	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTEI FORM	D: 11/10/2011 MAPPROVED
ISIALEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL	LTIPLE CONSTR	UCTION	(X3) DATE SURVEY COMPLETED	
		09G153	B. WIN	3			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>			10/:	26/2011
COMPO				1329 LONGFE	S, CITY, STATE, ZIP CODE ELLOW STREET NW DN, DC 20011		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PR (EAC)	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOL REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE
i i i i i i i i i i i i i i i i i i i	October 25, 2011, at confirmed the trainin logs/binder presente 25, 2011. 2. On October 26, 21 a.m., Client #1 begar heavily while seated i When queried, a dire was present at the tir "normal" behavior. S sometimes the client he breathed in this m breathing rapidly until minutes). A licensed arrived to the facility at the four clients' medic facility at 8:17 a.m. On October 26, 2011, eview of Client #1's p POS) dated October prescribed "Ventolin H nouth every six hours wheezing." The client /entolin inhaler that m ater that day, at appro tated she would verify rder was a "PRN, as pproximately 10:15 a. rimary care physician elephone moments ea PRN." She then replie	ealth and safety. cility's qualified intellectual hal and house manager on approximately 3:30 p.m., g was not in the training d to the survey team October 011, at approximately 6:45 breathing rapidly and n a chair in the living room. ct support staff person who he stated that this was he further indicated that was "calm" but sometimes anner. Client #1 continued 6:50 a.m. (approximately 5 practical nurse (LPN #2) t 7:08 a.m., administered ations and then left the beginning at 9:15 a.m., hysician's order sheets 2011, revealed he was IFA, inhale two puffs by for shortness of breath and was not administered the orning. When interviewed ximately 9:35 a.m., LPN #2 whether the Ventolin heeded" order. At m., LPN #2 stated that the had instructed her by rilier to change the order to ad "no." when asked if any.	W 34	2 W342 Compr has hir also the nurse. nursing The ori both the practice practice concent disease/ medicat health a develop for ensu services to develop for ensu services to develop for ensu services to develop for ensu services to develop for ensu services to develop for ensu services to develop for sensu services to develop for ensu services to develop for sensu services to develop for ensu services to develop for sensu services to develop for sensu for sensu fo	DEFICIENCY) ,2 ehensive Care II, In ed new LPN staff an e hiring of a new me All LPNs will under g orientation. entation will consist eoretical basis for e as well as a module a application rating on common illness identification ion administration. nd wellness tool will ed and used as a bas ring that care and are rendered accord opmental disability standards. Intation will be need in the LPN's hent file. ervisory RN and the l assume LPN overs pilities and all med- ill be observed ering medication at y 3 months. All	ight	
r	-rtin. She then replie	d "no," when asked if any d Client #1's episode of		observati	ons will be document ployee's file record.		1.30.N

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DEPA CENT	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 11/10/20 M APPROVI)11 ED
ISTATEME	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	OMB NO	<u> </u>	<u>91</u>
L	· · · · · · · · · · · · · · · · · · ·	09G153	B. WI	NG				
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	10/	26/2011	_
COMP	CAREII			13	329 LONGFELLOW STREET NW ASHINGTON, DC 20011			
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UI D BE	(X5) COMPLETIO DATE	N
W 342	a.m. that morning. I the aforementioned that she would bring to his day program is follow-up with the RI	ge 24 that was observed at 6:45 Upon hearing a description of observations, LPN #2 stated the client's Ventolin inhaler ater that morning and N to ensure that he had ailable at home and at his day	W	342				
W 362	The facility failed to e training on Client #1	ensure all staff received s health conditions as sure his health and safety	101 20					
	A pharmacist with inp	out from the interdisciplinary drug regimen of each client	W 36					
	review, the facility faile regimen reviews were	not met as evidenced by: n, staff interview and record ed to ensure that drug e conducted at least le two clients in the sample.						
	The findings include:							
	Client #1 was adminis	per 24, 2011, at 9:00 a m						

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STATEME	NT OF DEFICIENCIES	E & MEDICAID SERVICES	(72) 141		OMB NO.	APPROVI 0938-03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILL	LTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		09G153	B. WING		40/0	
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	6/2011
COMP	CARE			1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)		(X5) Completion Date
W 368	Review of Client #11 26, 2011, at 10:31 a received the medica diagnoses of hyper anemia, diabetes, g Record review on O revealed a pharmac June 4, 2011. There that drug regimen re least quarterly. Interview with the fac October 24, 2011, at revealed that Client a pharmacist made his March 2011. The LF that the pharmacy re required (quarterly). 2. On October 24, 20 administered Depako Haloperidol at 8:12 a medication administr medical chart on Octo revealed the pharmac of Client #2's medicat 2011 and June 4, 20 not being conducted a 483.460(k)(1) DRUG	ne, Risperdal, Ferrous Sulfate, rbonate, Clonidine, Aspirin, amide and Novolog. 's physician orders on October a.m., revealed that the client ations to address his tension, seizure disorder, laucoma, and hypertension ctober 24, 2011, 1:00 p.m., y review for Client #1 dated e was no evidence, however, eviews were conducted at cility's LPN Coordinator on t approximately 1:00 p.m., #1 was hospitalized when the s rounds to the facility in PN Coordinator confirmed eviews were not completed as 011, Client #2 was ote, Risperdal, Cogentin and .m. during the morning ation. Review of the client's ober 25, 2011, at 3:59 p.m., cist had documented reviews tion regimen on January 10, 11. Pharmacy reviews were at least quarterly. ADMINISTRATION	W 36		he he re	• O I • II
1	The system for drug a that all drugs are adm the physician's orders	administration must assure iinistered in compliance with				

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		HAND HUMAN SERVICES			FORM	11/10/2011 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G153	B. WING		10/2	6/2011
••••			s	TREET ADDRESS, CITY, STATE, ZIP CO 1329 LONGFELLOW STREET NW	DE	
COMP CA				WASHINGTON, DC 20011		.
(X4) !D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 368		-	W 36	¹⁸ W368, 1 A schedule will be set conform to the bi-wee	_	
	Based on observa review, the facility prescribed medica accordance with c	is not met as evidenced by: ation, interview and record failed to ensure that all tions were administered in lients' physician orders, for one in the sample. (Client #2)		administration of Hall as to be consistent wit physician's orders of administering Halope two weeks.	operidol so h the	
	review of Client #2 Records revealed 2011 - October 20 intramuscular inject 15th and 30th of e morning, however	de: 2011, beginning at 11:31 a.m., 's Medication Administration that during the period January 11, the client had received ctions of Haloperidol on the ach month. Earlier that , review of the client's sheets (POS) for the same		Every two weeks, the will review the Medica Administration Recor to ensure that medica are conforming to the MARs for all the four	ation ds (MARs) tion nurses schedule. residents	
	period revealed he 100 mg intramuso	e was prescribed Haloperidol ular injections every two weeks.		will be reviewed mont RN to ensure complia physician's orders.		11.29.1
	at approximately 5 and the qualified in professional acknown schedule for intrar address those mo weeks and, theref	nference on October 26, 2011, 5:00 p.m., the registered nurse ntellectual disabilities owledged that a twice monthly nuscular injections would not nths in which there were five ore, not ensure that Client #2 dol every two weeks, in he POS.				
W 369	were administered	d to ensure that all medications without error. [See W369] UG ADMINISTRATION	W 3	W368, 2 Please refer to W369.		
	The system for dr	ug administration must assure uding those that are				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM): 11/10/2011 / APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S COMPL	
		09G153	B. WINC	G	- 10"	00044
NAME OF I				STREET ADDRESS, CITY, STATE, 1329 LONGFELLOW STREET WASHINGTON, DC 20011	ZIP CODE NW	26/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE	OF CORRECTION ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
W 369	Continued From pa self-administered, a	age 27 are administered without error.	W 36	69		
:	 Based on observation review, the facility facility facility 	s not met as evidenced by: tion, staff interview and record ailed to ensure clients ns without error, for one of the nple. (Client #1)				
	The findings include	es				
	on October 24, 201 Client #1 received I Tegretol, Acetazola Amlopidine, Risperc Calcium Carbonate, Multi-Delyn, Dorzola same day, at 11:11 medication administ current POS dated (Nasonex Nasal Spra	amide and Novolog. On the a.m., review of the client's tration record (MAR) and October 2011, revealed that ay and Ventolin HFA inhaler ot observed during the				
	at 10:18 a.m., the lic (LPN #1) confirmed and Ventolin HFA in	erview on October 24, 2011, eensed practical nurse #1 that Nasonex nasal spray haler were omitted from e morning of October 24,				
	Client #1 was observ living room. At appro client began breathir seated. A direct sup	1, beginning at 6:27 a.m., yed seated in a chair in the oximately 6:45 a.m., the ag rapidly and with force while port staff person who was tated that this was "normal"				

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 11/10/2011
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		09G153	B. WINC	3	10/06/0044
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/26/2011
COMP C	AREII			1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE COMPLETION
	Client #1 continued 6:50 a.m. LPN #2 a a.m. and administer medications. LPN # [Note: Upon hearing aforementioned obs 10:15 a.m., LPN #2 the client's Ventolin later that morning ar ensure that he had \ home and at his day On October 26, 201 review of Client #1's (POS) dated Octobe prescribed "Ventolin mouth every six hour wheezing." The clien Ventolin inhaler. Wh morning, at approxim stated she would ver order was a "PRN, at approximately 10:15 primary care physicia change the order to " revealed that no staff shortness of breath the acknowledged that sl Client #1's Ventolin in POS. 2. The morning medi observed on October a.m. At approximatel oreparing Client #1's Sodium Bicarbonate (imes the client was "calm." the short, hard breaths until arrived to the facility at 7:08 red the four clients' #2 left the facility at 8:17 a.m. a description of the servations, at approximately stated that she would bring inhaler to his day program ind follow-up with the RN to /entolin inhalers available at program.] 1, beginning at 9:15 a.m., physician's order sheets er 2011, revealed he was HFA, inhale two puffs by rs for shortness of breath and int was not administered the hen interviewed later that hately 9:35 a.m., LPN #2 ify whether the Ventolin	W 36		n will pasis dule and A l be sis ding sight pass

Facility ID: 09G153

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		HAND HUMAN SERVICES					ED: 11/10/201 RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	NO. 0938-0391 E SURVEY IPLETED
			A. BUI				
		09G153	B. WIN	IG		1	0/26/2011
	PROVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 129 Longfellow Street NW 14SHINGTON, DC 20011		
	Continued From para At 7:38 a.m., LPN 4 medications. a. On October 26, 2 review of Client #1's revealed the physic Bicarbonate 650 mg hours for gastritis." client's October 201 Record (MAR) reve for taking the Sodiu 12 p.m., 6 p.m. and On October 26, 201 presented two bliste Bicarbonate. One h and the other was n administration time. for 8 a.m." She furth pack of Sodium Bica Client #1's day prog nurse (RN) was inte beginning at 12:30 p should be 6 blister p administrations in th administrations in th administrations on Client #1 had not be Bicarbonate 4 times POS. b. On October 26, 20 review of Client #1's revealed the physicia spray, instill one spra	 #2 administered Client #1's 2011, beginning at 8:30 a.m., s POS dated October 2011, ian ordered "Sodium g tablet 1 tab by mouth every 6 Concurrent review of the 11, Medication Administration aled that the designated times m Bicarbonate were 6 a.m., 12 a.m. 1, at 9:42 a.m., LPN #2 er packs of Sodium had been labeled "bedtime" ot marked with an LPN #2 stated "this one is her stated that a third blister arbonate had been sent to ram. The facility's registered rviewed on October 26, 2011, 0.m. She stated that there backs total, to reflect the 3 e home, the noon y program on weekdays and 	ID PREFI TAG	69	W369, 2a The facility's RN will, on monthly basis compare a Physician's Orders with the corresponding MARs to on that transcription of order consistent with Physician Orders Sheets. All LPNs will undergo nutorientation. The orientation orientation. The orientation consist of both theoretical for practice as well as a mone practical application concentrating on commone disease/illness identification medication administration health and wellness tool we developed and used as a b for ensuring that care and services are rendered account to developmental disability nursing standards. The orientation will be documented in the LPN's employment file. The supervisory RN and the DON will assume LPN over responsibilities and all med LPN's will be observed administering medication and least every 3 months. All observations will be docum- in the employee's file record	Il their ensure ers are 's rsing on will basis odule on and a. A ill be asis ording y he trsight 1-pass at	COMPLETION DATE

Facility ID: 09G153

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If continuation sheet Page 30 of 33

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			FOR	D: 11/10/2011 M APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G153	B. WING		10	0010044
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	<u> </u>	26/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 381	Initials on the docur administered the na throughout the morr process, however, f of the nasal spray in POS. 483.460(I)(1) DRUG RECORDKEEPING The facility must sto conditions of securit This STANDARD is Based on observation review, the facility fa under proper condition four clients residing if #3 and #4) The findings include: 1. On October 24, 2 a licensed practical r administering the clie At 8:21 a.m., the mean the dining room) was unsecured while the and went to the kitch surveyors remained if medications were una After the medication a acknowledged that the unsecured. 2. On October 24, 20	d that LPN #2 had placed her nent as if she had isal spray. Observations ning medication administration ailed to include administration accordance with Client #1's STORAGE AND re drugs under proper y. not met as evidenced by: on, interview and record iled to store medications ons of security, for four of the in the facility. (Clients #1, #2,	W 369	LPN #2 has been in-service medication administration regimen. All LPNs will undergo nur orientation. The orientation consist of both theoretical	sing n will basis odule n, and nd ped uring	11-30-n

Facility ID: 09G153

If continuation sheet Page 31 of 33

DEPAP CENTE	RTMENT OF HEALTH ERS FOR MEDICARE	HAND HUMAN SERVICES			FOR	D: 11/10/201 MAPPROVEL O: 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE	
		09G153	B. WING		10	128/2044
NAME OF	PROVIDER OR SUPPLIER		st	REET ADDRESS, CITY, STATE, ZIP CO		26/2011
COMP			· · ·	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	difficult to administer handed the medica staff who subseque medications with we observed to attemp medications. When interviewed a administration, the of she was not a trainer (TME). Concurrent qualified intellectual October 24, 2011, a revealed the facility used licensed nurse medications. Review of the facility October 25, 2011, b confirmed that the fac certified TMEs. The staff who was obser his medications was access to the client's 3. During the mornin on October 24, 2011 observed retrieving a The jar contained the and three vials of La prescribed for Client revealed no evidence Interview with LPN # 9:10 a.m. revealed the however, the nurse factors in the staff the of the staff who was observed the staff who was observed the jar contained the staff who was observed the staff who was obse	med the surveyor that it was er the client his medications, tion cup to a direct support ntly administered the ater. At no time was LPN #1 t to administer the client his after the medication direct support staff stated that ed medication employee interviews with LPN #1 and disabilities professional on t approximately 10:15 a.m., did not use TMEs; they only as to administer clients' A's personnel records on eginning at 10:00 a.m., acility was without any refore, the direct support ved administering Client #4 not authorized to have	W 381	W381,1 LPN #1 has been relieve duties with Comprehen II, Inc. All LPNs working with Comprehensive Care II be trained on medicatio administration guidelin include among other top infection control, securi medication cabinet, and observing privacy durin medication administrati The supervisory RN and DON will assume LPN of responsibilities and all r LPN's will be observed administering medication least every 3 months. A observations will be doc in the employee's file re	sive Care , Inc. will n es to pics: ng the g ion. d the oversight ned-pass on at ll umented	11-30-11

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		E & MEDICAID SERVICES	·			M APPRO 0. 0938-0
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	
		09G153	B. WING		10	/26/2011
COMP C	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CO 329 LONGFELLOW STREET NW VASHINGTON, DC 20011		
	(EACH DEFICIENCY REGULATORY OR L Defore. When inte acknowledged that secured with a lock October 25, 2011, a registered nurse sta should be secured in 4. The morning me observed on Octobe a.m. Another LPN administered the me #2 walked out of the door to the medicati clients and surveyor sitting in the dining a returned to the dinin minutes later. Later approximately 10:00 that she had left the	erviewed further, the LPN all medications should be . When interviewed on at approximately 1:00 p.m., the ated that all medications under lock. edication administration was er 26, 2011, beginning at 7:09 (LPN #2) prepared and edications. At 7:42 a.m., LPN e dining room, leaving the ion cabinet wide open. Staff, rs were observed walking and room at the time. The LPN bg room approximately 1 1/2 r that morning, at 0 a.m., LPN #2 acknowledged e door to the medicine cabinet it to the bathroom to wash her ing the four clients' ired.	ID PREFIX TAG W 381	W381,2 LPN #1 has been relieved duties with Comprehensive Inc. All LPNs working with Comprehensive Care II, I trained on medication administration guidelines among other topics: emph the LPNs are the only aut staff to administer medica Direct Support Staff have advised not to participate participation of medication administration. Agency LI nursing staff will attend a mandatory orientation wh include medication admini with sub-sections on medic storage, MAR and nursing documentation. The super RN and the Agency DON v assume oversight responsil ensure that medication into being maintained. In addit med-pass nurse will be obs least quarterly administeri medication and treatments individuals. Special attenti be paid to medication administration techniques a documentation.	ve Care II, nc. will be to include asis that horize tions. been in direct n PN ich will stration ation note visory vill pility to egrity is tion each erved at ng to on will and will strate visory vill pility to egrity is tion each erved at ng to on will and	(X5) COMPLE DATI

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PRINTED: 11/10/2011 FORM APPROVED

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0127				10/26/2011
AME OF PROVIDER OR SUPPLIER				TATE, ZIP CODE	
			GFELLOW S TON, DC 20		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE COMPLE
1 000 INITIAL COMMEN	TS		1 000	DEFICIENC	<u>m</u>
A licensure survey 24, 2011 through (two residents was	was conducted from October 26, 2011. A s selected from a popu ing degrees of intelled	sample of lation of			
observations, inten in the home and at	survey were based o views with staff and re two day programs, a t and administrative r eports.	esidents 🤌			
facility: (1) failed to system had been d make certain that F levels were tested v ensure that Reside injections as prescr safety. The facility' likely harm to Resid	LA) determined that t ensure that an effect eveloped and implem Resident #1's blood gl while fasting; and, (2) nt #1 received insulin ibed to ensure his he s practices, therefore lent #1. On October i cility's administrator w	ive hented to ucose failed to alth and , posed 25, 2011,			: :
the facility's adminis director of nursing e correction (POC) to jeopardy. The HRL the facility's adminis director of nursing (5:12 p.m. to 5:26 p. assistant and the De proposed corrective be implemented implication dinner. An amende approximately 6:50	1, at approximately 5 strative assistant and address the immedia A survey team met or strative assistant and DON) from approxim m. The administrativ ON agreed to suppler plan by adding meas mediately that evening d POC was presented p.m. Compliance and the corrected actions w	their a plan of ate nsite with the ately e ment the sures to g, before d at			
h Regulation & Licensing Adminis			B	TITLE	(X6) DATE
RATORY DIRECTOR'S OR PROVID	manary	recht	/ >	Administration	

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PRINTED: 11/10/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N HFD03-0127	LIER/CLIA NUMBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPP		070000			10/26/2011
	LIEK			TATE, ZIP CODE	
		WASHIN	NGFELLOW S GTON, DC 20	STREET NW 0011	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENC IENCY MUST BE PRECEDED B OR LSC IDENTIFYING INFORM	IV FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
1 000 Continued From	n page 1		1 000		
observed prior jeopardy.	to the removal of the im	mediate			
The following w facility that outli measures:	ras the plan submitted b ned the proposed corre	y the ctive			:
# I s pnysician's medication/trea Medication Adm health passport	ed nurse (RN) will review orders (POS), tment, consult and track ninistration Records (MA and health management and completeness.	king forms,			
diabetic training individual-specif management, pl	re. All nursing staff will by October 26, 2011, to ic training, medication hysician/RN notification, and Comprehensive Ca	receive include:			
are scheduled an will be forwarded (PCP) for review forwarded to the	nsure all medical appoin nd completed. Consult to the primary care phy . All verbal orders will b PCP for review/signature text business day.	orders /sician			
verbal/wntten rep in the appropriate The RN will be no The RN will ensu the MARs and PO the onsite nurse a POS will be forwa	se will contact the RN we port and will file the conse e section of the medical otified of all abnormal fir re all new orders are po DS. All POS will be revi- after each appointment. after each appointment. arded to the pharmacy a R/POS by the onsite nu	ult form book. ndings. sted on ewed by The			:

Health Regulation & Licensi STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA (X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
	HFD03-0127	A. BUILDING B. WING		COMPLETED
NAME OF PROVIDER OR SUPPLIER				10/26/2011
		STREET ADDRESS, CITY, S	TATE, ZIP CODE	
		1329 LONGFELLOW S WASHINGTON, DC 20	STREET NW	
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMAT	JLL ID ONN PREFIX	PROVIDER'S PLAN OF	
		TAG	CROSS-REFERENCED TO DEFICIENC	
1000 Continued From pa		1 000		
The onsite nurse	will document in a pro	Oress		
nore an activities an	Q Will inform the modie	of in m		
Pass nuise of any c		- FF		
	'IO Medication admini-	American I		
010010pa110165/30110	(Mai tindinge will be be	augusta à		
clarification.	e RN and PCP for revi	ew and		
A A				
6. Comprehensive C	are II will ensure that t	he		
racing is properly sta	TTPC for modioatian			
authinistration the	RN will be notified if no	oper		
staffing is not availab	ole.	•		
7. The RN will observ	ve the licensed practica			
nurse (LPN) and me	dication pass nurse at			
every 3 months.	aloation pass nurse at	east		
8 The PCP will reach				:
tracking/observation i	ve a copy of all pertine information with each v	nt risit.		
p.m. outlined the follo	itted at approximately wing:	6:50		
	-			
insulin clarification	phoned for finger stick	and		
insulin clarification. C	urrent orders read fing	er -		
stick prior to each me	al and bedtime written	by :		
endocrinologist at last which the PCP had re	appointment (8/30/11,			
The PCP returned the	Call at 5:45 p.m. David	•		
orders from hospital di	ischarge of 2/2014	ewed		
10110W-up VISIT //2011	and endocrinologies over	014		
	20/Contirmed Tologha			
	10 each meal and her	!		
wedunie. Oliuling scale	10 DP 20 ministered her			
	it resident opto held su			
stick. Will fax verbal on and confirmation.	ders to PCP for his rev	iew		
				:
2. Observed <lpn #1=""> check at 5:47 p.m.; res</lpn>	complete finger stick			:
Check of 5.47 m mains				

STATE FORM

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
AME OF PROVIDER OR SUPPLI		070557 4000		······································	10/26/2011
				TATE, ZIP CODE	
OMP CARE I I		1329 LONG	FELLOW S DN, DC 20	STREET NW 1011	
FREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY I R LSC IDENTIFYING INFORMA	E1 11 1	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
1 000 Continued From		1	000		
signs/symptoms Resident #1 was housemates.	of hypo/hyperglycemia. able to then eat with his	•			
3. Verbal report of on POS/MAR.	given to <lpn #1=""> writte</lpn>	n orders			
nurse has been a	en removed from the sc ately. Another medicatio issigned medication atment (including Reside ection)	n pass			:
MAR. The TO wa morning as follow	er (TO) posted and place section of POS and post as further clarified the ne s: "Hold finger stick for 2 and check blood glucose	sted on ext			
1 090 3504.1 HOUSEKE	EPING	10	90		
maintained in a sa and sanitary manr	xterior of each GHMRP s fe, clean, orderly, attract er and be free of dirt, rubbish, and objectio	tive,			:
Group Home for P Disabilities (GHPI	t met as evidenced by: tion and staff interview, t ersons with Intellectual)) failed to ensure its inte a manner that ensured t hts. [Resident #1]	rior			• • •
The finding include	S:				
Observation on Oc 3:45 p.m. revealed	tober 24, 2011 beginning Resident #1 walked with	y at			

PRINTED: 11/10/2011

Health Regulation & Licensir	ng Administration			FOR	ED: 11/10/20 M APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	IBER:	MULTIPLE CONSTRUCTION		E SURVEY PLETED
	HFD03-0127	B. V	VING	_	10010044
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS,	CITY, STATE, ZIP CODE	10	/26/2011
COMP CARE I I		1329 LONGFELI WASHINGTON, I	LOW STREET NW DC 20011		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FOR SC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF C	ON SHOULD BE	(X5) COMPLE DATE
1 090 Continued From page	ge 4	1 090		,	
very quick shuffled g small and choppy as the environment rev room and the kitche materials and were of threshold in the door surfaces was missin surfaces was approx Interview with the fac October 26, 2011 at confirmed this unfinite between the two surf Resident #1 due to h I 180 3508.1 ADMINISTRA Each GHMRP shall p administrative suppor needs of the resident Habilitation plans.	gait. His steps were vis s he walked. Observa- vealed the floor in the f en were made of differe of different height. The rway between the two ng. The gap between the ximately 1-1 ½ inch will cility's house manager approximately 10:30 a shed part of the floor faces poses a trip haz bis unsteady shuffled g ATIVE SUPPORT provide adequate int to efficiently meet the ts as required by their the as evidenced by: n, staff interview and re ne for persons with s (GHPID) failed to ensi- ive staff to effectively r for one of the two resi- dent #2) 9.1] There was no evid e trained on the residen ds.	ery ation of iving ent ive the two de. on a.m., ard to pait. I 180 ne ecord sure meet idents dence ork nt's	I 090 The unfinished part of has been fixed. Once monthly, the madivision and the Hous will conduct internal external environment ensure compliance.	aintenance se Manager and	11-0]-
ensure that the one-to with Resident #2 had on h Regulation & Licensing Administra	-one staff assigned to current training and	work			

STATE FORM

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Health Regulation & Licensing Administration

STATEMENT OF DE AND PLAN OF COR	RECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0127	MBER:	A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED 10/26/2011
COMP CARE I			1329 LON		STATE, ZIP CODE STREET NW 20011	•
COMP CARE I I (X4) ID PREFIX TAG I 180 Contin certific accomplan. 3. On admin Halop medic reveal that re 60.60 [Note: May 19 Octobe residen eviden others Medica abnorr 15, 20 On Oc	SUMMARY STA ACH DEFICIENCY GULATORY OR LS nued From participation in crisis dance with the October 24, 2 istered Depak eridol at 8:12 a al chart on Oc ed a lab repor flected a high ng/ml (referen Other lab repor flected a high ng/ml (referen Other lab repor flected a high ng/ml (referen Other lab repor er 25, 2011, al nt's psychiatric ce that the pre participating c ation Review to hal prolactin le 11.	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA ge 5 prevention procedur e resident's behavior 011, Resident #2 wa tote, Risperdal, Coge a.m. Review of the r tober 24, 2011, at 3: t dated February 15, serum prolactin leve ice range 2.5 - 17.0 i orts dated May 24, 2 t reflect prolactin test t 11:50 a.m., review ic precords revealed no escribing psychiatrist on the resident's Psy eam were made awa evel reading from Fei l, at 12:41 p.m., the fei l) stated "the psychiatrist	1329 LON WASHING FULL TION) res, in support s entin and esident's 45 p.m., 2011, 1 of ng/mi). 010 and ting.] On of the o and chotropic ire of the oruary	IGFELLOW	STREET NW	COMPLETE COMPLETE ROPRIATE DATE
p.m., the records Review findings There we that Re made a 15, 201 4. The Individu objective	te RN examin s, including the forms, and co s. vas no eviden sident #2's pro ware of serun 1, showing ele GHPID failed al Program Pl es to meet the	person's labs." At 1; ed Resident #2's psy e Psychotropic Medic onfirmed the aforem ce that the GHPID e escribing psychiatrist n lab tests, dated Fe evated prolactin leve to ensure that Resid an (IPP) included tra e resident's needs as interdisciplinary tear	rchiatric cation entioned nsured was bruary ls. ent #1's ining		Once monthly, the facility's QIDP and RN will review a medical records to ensure t abnormal lab values and recommendations from con are communicated to the psychiatrist and other mem of the support team for all clients being supported.	all that isults

6899

Health I	Regulation & Licensir	ng Administration			F	
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		(X2) MUL A. BUILDI B. WING	ING C	ATE SURVEY OMPLETED
	PROVIDER OR SUPPLIER	T	070557.40			10/26/2011
COMPC			1329 LON		, STATE, ZIP CODE / STREET NW 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	 continuous active tr 6. The GHPID faile documented in acco support plan (BSP). Report - Citation W2 3510.3 STAFF TRA There shall be conti 	d to ensure residents eatment. [See I422] d to ensure behavior ordance with the beha [See Federal Deficie 252]	data was avior ency rvice	180 222	I 180,4Please refer to I 420I 180,5Please refer to I 422I 180,6Please refer to W252I 222,1All staff have been trained on signs and symptoms of	
	This Statute is not r Based on staff inten the group home for disabilities (GHPID) in-service training fo symptoms of hyper/l of breath as recomm health and safety, fo sample. (Resident # The findings include 1. Record review or approximately 10:10 was taken to the loca 2011, for emergent of glucose levels (375 r Further record review approximately 10:40 investigation, dated I recommended that a and symptoms of hyp February 18, 2011."	met as evidenced by: view and record revie persons with intellect failed to provide onger r staff on signs and hypoglycemia and sho hended to ensure resi- r one of two residents 1) a October 25, 2011, a a.m. revealed Reside al hospital on January care due to elevated the mg/dl) and a swollen w on the same day, at a.m., revealed the er February 5, 2011, ill "staff be trained on po/hyperglycemia by y's in-service training	w, the ual oing ortness ident s in the t ent #1 / 18, blood face. t nsuing signs		hypo/hyperglycemia. The oversight supervisory RN and the Agency's Director of Nursing (DON) will develop scheduled time frames for the quarterly reviews of client health status and each client's medication regimen. In-service training modules will be developed by the Agency's DON for both LPN and DSS on signs and symptom of common and specific illnesses/medical conditions including shortness of breath (SOB), sexuality, nutrition, communications, and assistive devices, emergency procedures, disaster plans and fire evacuation procedures. All direct care staff will be required	
	on October 25, 2011 revealed there was n	at approximately 2:0)0 p.m.		to maintain current basic First Aid and CPR certification.	11.30.11

Health Regulation	& Licensing	Administration

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NAME OF F	PROVIDER OR SUPPLIER	HFD03-0127		B. WING		10/26/201	
COMP C				IGFELLOW GTON, DC 2	STREET NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
	Continued From pareceived training on ensure Resident #1 Interview with the fa disabilities professio October 25, 2011, a confirmed the trainin logs/binder presente 25, 2011. 2. On October 26, 2 a.m., Resident #1 be heavily while seated When queried, a dim was present at the ti "normal" behavior. sometimes the resid sometimes the resid sometimes he breatt #1 continued breath (approximately 5 mir nurse (LPN #2) arriv administered the four then left the facility a	hypo/hyperglycemia 's health and safety. Incility's qualified intel onal and house mana thapproximately 3:30 mg was not in the traised to the survey tear 2011, at approximate egan breathing rapid in a chair in the livir ect support staff per ime stated that this w She further indicated lent was "calm" but hed in this manner. ing rapidly until 6:50 nutes). A licensed p red to the facility at 7 or residents' medicated	lectual ager on) p.m., ining n October ely 6:45 ily and ag room. son who was 1 that Resident a.m. ractical :08 a.m.,	1222	I 222,2 Please refer to I 222,1		
	On October 26, 2011 review of Resident # (POS) dated Octobe prescribed "Ventolin mouth every six hour wheezing." The resid the Ventolin inhaler the interviewed later that a.m., LPN #2 stated Ventolin order was a approximately 10:15 primary care physicia telephone moments of 'PRN." She then report of the staff had report	1's physician's order r 2011, revealed he HFA, inhale two puf rs for shortness of bo dent was not admini- hat morning. When t day, at approximate she would verify whe "PRN, as needed" of a.m., LPN #2 stated an had instructed he earlier to change the blied "no," when asket ted Resident #1's en	sheets was fs by reath and stered ely 9:35 ether the order. At I that the r by order to ed if any pisode of				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION			(X2) MULT A. BUILDIN B. WING	IG	TE SURVEY MPLETED 10/26/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS. CITY.	STATE, ZIP CODE	10/20/2011
COMP C	AREII		1329 LON		STREET NW	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE
1222	the aforementioned that she would brin inhaler to his day p follow-up with the F Ventolin inhalers ar program. Review of staff in-s October 25, 2011, I revealed no eviden training on Resider of breath and whee The facility failed to training on Residen	Upon hearing a desc d observations, LPN a g the resident's Vento rogram later that mor RN to ensure that he l vailable at home and service training record beginning at 2:00 p.m ice that staff had rece at #1's diagnosis of "s	#2 stated olin ming and had at his day ls on h., ived hortness ved ns as	I 222		
l 227	3510.5(d) STAFF T Each training progra limited to, the follow	am shall include, but	not be	1 227		:
	cardiopulmonary re	cedures including first suscitation (OPR), th , disaster plans and f	e :		I 227 Staff #5 and Staff #13 have submitted current CPR and First Aid Certifications.	
	Based on staff inter group home for per- disabilities (GHPID) fourteen (14) staff a consultants failed to certification on reco	rd to ensure the heal ur residents of the fac #3, and #4)	ew, the (2) of th and		The human resources department will, on a monthly basis audit all personnel records to ensure that certifications are current or updated in a timely manner.	11.29.1

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU HFD03-0127		(X2) MULTII A. BUILDING B. WING		(X3) DATE COMPI	SURVEY LETED 26/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS. CITY, S	TATE, ZIP CODE	10/	20/2011
COMP C			1329 LON		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
l 227	Continued From pa	-		227			
	11:00 a.m., reveale	Dctober 25, 2011, be d Staff #5 and Staff R and First Aid certifi	#13 failed 🗄				
	October 26, 2011, a confirmed the abov she would have the	acility's house managed at approximately 10:4 e findings and also in oversight corrected rming the qualified ir	45 a.m., ndicated				-
	disabilities professio department.	onal and the human	resources				:
I 229	3510.5(f) STAFF TI	RAINING		l 229			
	Each training progra limited to, the follow	am shall include, but ⁄ing:	not be				
	(f) Specialty areas r residents to be serv to, behavior manage recreation, total con technologies;	ement, sexuality, nut	limited rition.				
	This Statute is not a Based on staff inter- group home for pers disabilities (GHPID) received training on intervention, includir	view and record revie sons with intellectual failed to ensure that all facets of behavio ng crisis procedures,	ew, the staff r for one				:
	of the two residents	in the sample. (Res	ident #2)				:
	The findings include						
	1. On October 26, 20 with Resident #2's d revealed that on Oct became aggressive morning. The reside	ay program case ma ober 10, 2011, the re shortly after his arriv	nager esident al that				

Health Regulation & Licensing Administration

STATEMENT OF D AND PLAN OF CO	DEFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD B. WING			E SURVEY PLETED
NAME OF PROVID		HFD03-0127	17			10	/26/2011
COMP CARE I	 		1329 LON WASHING	GFELLOW	, STATE, ZIP CODE / STREET NW 20011		
(X4) ID PREFIX TAG F	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JULD BE	(X5) COMPLETE DATE
After retur the r day p reco Furth prog staff prese the q (QID Plan Septe declin progr On C a.m., 2011 QMR ensur are tr plan.' Activi the fo staff' Wher 2011, #2's o trainir Resid progra implei trainir	n home, the fac esident home. program for the mmended by the ner interview re- ram had sough from the reside ented documen (ualified intellec P) at the reside (ISP) meeting I ember 29, 2011 ned her request ram staff. October 25, 201 review of Resid , revealed the fac P and supervise ring that all who ained to implent ' At 11:19 a.m. ty Schedule, da blowing: "Suppor while at the day on the QIDP was at 3:50 p.m., he lay program have ng for their staff ent #2 resides am was respon- menting a beha- ng their staff.	e staff recommended cility van returned an Resident #2 did not next two weeks, as ie psychiatrist. vealed that Resident t in-service training fi- initial psychologist. S tation of requests ma- tual disabilities profe- nt's annual Individua- held June 7, 2011, and the QIDP reporte- ts for training the day 1, at approximately 1 dent #2's ISP, dated ollowing: "The resided onlowing: "The resident nent the behavior sup , review of the resident , review of the	d drove return to #2's day or their the ade to ssional I Support dly 0:00 June 7, ntial ible for 's name> oport ent's vealed rogram ber 26, sident te ause and SP) and	1229	I 229, 1 Client #2's day program s will be trained on Novema 2011 by the psychologist of residential facility. Comprehensive Care will develop a Policy and Proce related to Individual Servit Coordination and Communication. This pol will outline the procedure coordination and collabors with day and other suppor program providers. The po- will also address training requirement, behavior dat documentation, and protoco for interdisciplinary team communication to guarant that each identified team member is notified and ma aware of any incident, and request by other agencies to may require immediate intervention to ensure cont support of the client's/individual's care or service goals.	ber 29, of the edure ice icy for ation rt olicy a cols ee de hat inued	12.03.11
that a	ll staff who worl	ce that the QIDP ensitive with Resident #2 w nt's behavior support	ere				: :

Health Regulation & Licensing Administration STATE FORM

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Health Regulation & Licensing Administration				
	Health	Regulation 8	Licensing	Administration

AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDII B. WING	TIPLE CONSTRUCTION		e survey Pleted
	PROVIDER OR SUPPLIER	HFD03-0127	STREET ADDRESS, CITY, STATE, ZIP CODE		1(0/26/2011	
			1329 LON		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FUH	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
1229	Continued From pay 2. [Cross-refer to 12: 11:35 a.m., interview program case mana could become "extre one-to-one staff ass daytime hours to en- and others. On October 24, 201 Resident #2's BSP r trained one-to-one s restrictive crisis prev by the DDS in order <resident's name=""> a Personnel records a records were review beginning at 2:00 p.r cards on file docume both of whom were a Resident #2 as his o training in the past. indicated the certifica 2011.</resident's>	29.1] On October 26 w with Resident #2's ager revealed that the emely violent" and ha- igned to work with h sure the safety of Re 1, at 2:15 p.m., revie evealed the following taff should use only vention procedures a to secure the safety and that of others." Ind staff in-service tra- ed on October 25, 20 m. There were certife enting that Staff #1 a assigned to work with ne-to-one, had receind The cards, however,	day e resident ad a im during esident #2 w of g: "The the least pproved of aining D11, ications nd #2, ved said	1229	I 229, 2 Client #2's staff (Staff have been scheduled to refresher course on Cr Prevention and Interva (CPI) techniques on Do 2011 and December 12 Other facility staff will such training on the ab mentioned days. The administrative ass consonance with the Q on a monthly basis revi personnel records to en training records and of certification requireme updated timely.	o attend a ises ention ecember 9, , 2011. receive oove- istant in IDP will iew all usure that	
	On October 26, 2011 facility's administrativ was aware of the trai that CPI training had There was no eviden that all staff who worl trained on the resider 3512.2 RECORDKEE	ve assistant revealed ining need and she s not yet been schedu ice that the QIDP en k with Resident #2 w nt's behavior support	I that she tated iled. sured ere t needs.	1264			
	Each record shall be made available at all tion & Licensing Administr	kept in a centralized times for inspection	file and	1261			

STATE FORM

Health Re	gulation &	Licensina	Administration

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STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0127	R/CLIA MBER:	(X2) MUL A. BUILDI B. WING		. Сом	E SURVEY PLETED
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE		/26/2011
COMP C			1329 LOP		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
1 420	agencies. This Statute is not Based on staff inter facility failed to ensu were made available	I of authorized regula met as evidenced by view and record revie are that all personnel to the survey team 26 personnel. (LPN 26 personnel. (LPN 26 personnel. (LPN 27 personnel. (LPN 28 professional (QIDI P indicated the personnel ager (HM) and the q 29 professional (QIDI P indicated the personnel ager (HM) and the q 29 professional (QIDI P indicated the personnel ager (HM) and the q 29 professional (QIDI P indicated the personnel could be brought to the could be brought to the (October 25, 2011). 10:45 a.m., the personnel records on Octo ely 1:30 p.m., revealed LPN #1 was not incl The facility failed to cord for 1 out of 26 e available for review with this section.	ew, the records for #1) 2:30 a.m., I records ualified 2). Both onnel vere fice. the onnel n. ober 25, ed the uded or ensure v to	I 261	I 261 This was an oversight A tracking system wil place to ensure that al records are presented of review.	I be put in I personnel	10.30.1
	training to its residen and maintain those li more effectively with environments and to of physical, mental a	ts to enable them to fe skills needed to co the demands of their achieve their optimu	acquire ope r m levels				•

Health Regulat	ion & Licensii	ng Administration				FORM APPROVED
STATEMENT OF DEI AND PLAN OF CORF	FICIENCIES RECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0127	R/CLIA MBER:	(X2) MULT A. BUILDII B. WING	NG	3) DATE SURVEY COMPLETED
NAME OF PROVIDE		1-003-012/	OTREET ADD			10/26/2011
COMP CARE II			1329 LON		STATE, ZIP CODE STREET NW 20011	
(X4) ID PREFIX (E TAG RE	ACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
This S Based review intelled habilitä enable neede achiev one of #1) The fin On Oc arrived direct of resider was ob turning observe flipping if the st pleasin his hea Review dated J 10:31 a develop remote while in Review 7, 2011 11:30 a program recomm	on observati t, the group he ctual disabiliti- ation and train them to acquid to cope with e optimum le the two resid ding includes tober 25, 201 home from a care staff was not in a chair in served retrievent on the televise ed using the resid d in an up an to f Resident second of Resident second to a program for control device a seated pose of the individ to address televise to address televise w with the quarters to a with the quarters to a with the quarters to address televise to address televise to address televise to address televise to address televise to address televise telev	met as evidenced by on, interview and recome for persons with es (GHPID) failed to hing to its residents the uire and maintain life their environments a vel of social functioni ents in the sample. (at 1, at 11:50 a.m., Res doctor's appointmer observed placing the the living room. The ving the remote contrision. The staff was fil elevision remote contributes and asking the tay." Once a channe ent he responded by d down motion. #1's psychology asses on October 26, 2011 a recommendation to the him to learn how to e to turn the televisio sition. ual program plan dat 26, 2011, at approximino evidence of a trai he aforementioned the psychologist.	ord provide nat would skills and ng, for Resident ident #1 nt. The estaff of and urther trol, resident I was moving ssment , at o use a n on/off ed June nately ning	1420	I 420 A training goal for the use of television remote control by client #1 has been put in place All Direct Support Staff (DSS and the House Manager (HM have been trained on the implementation of client #1's remote control program. On a monthly basis, the facilit QIDP and RN will review habilitation records of all the clients to ensure that recommendations are adhered as specified. Quarterly Audit will be done I the quality assurance person to ensure that all recommendation are implemented as specified.	e. ()) (y's I to by o
alth Regulation & Lice		on October 26, 2011,	al 4.10			

Health Regulation	ጲ	Licensing	Administration
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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		HFD03-0127		B. WING		10/	26/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMP C	ARE		1329 LON WASHING	GFELLOW STON, DC 20	STREET NW 0011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FUL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
I 420	Continued From page	ge 14		I 420	······································		
	p.m., revealed that I recommended traini training program ha	ing objective and the	the erefore no				
I 422	3521.3 HABILITATI	ON AND TRAINING		422			
	Each GHMRP shall and assistance to re the resident 's Indivi	sidents in accordan	ce with				• •
	This Statute is not n Based on observatio review, the Group He Intellectual Disabilitie that residents receive as prescribed in their one of the two reside #1)	on, interview and rec ome for Persons wit as (GHPID) failed to ed habilitation and a r Individual Support	ord h ensure ssistance Plan, for				
	The findings include:		2 1				
	Observations on Oct a.m. until 8:55 a.m., i in a chair at the dinin the resident was obs the van and going to arrived home from da was observed until 5: he received personal assisted to the living living room, he was o	revealed Resident # g room table. At 9:0 erved being assisted day program. Resid ay program at 3:40 p :40 p.m., during white hygiene care and w room. While seated	1 sitting 00 a.m., d onto dent #1 0.m. He ch time vas l in the				
	living room, he was o elevated on an ottom snack while he remai staff was observed as dining room for dinne from 12:05 p.m. until observed sitting in the television with his fee	an and had an even ned seated. At 5:40 ssisting the resident r. On October 25, 2 2:00 p.m., Resident e living room watchir	ing) p.m., to the 011, #1 was				
	n an interview on Oc tion & Licensing Administra	tober 25, 2011, at	44 (1984) - 48 (1984)				

Health I	Regulation & Licensir	ng Administration				PRINTED FORM	: 11/10/2011 APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	A. BUILD		(X3) DATE S COMPLE	
	· · · · · · · · · · · · · · · · · · ·	HFD03-0127		B. WING)	10/2	6/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CIT	r, STATE, ZIP CODE	10/2	0/2011
COMP C	AREII		1329 LON WASHING	NGFELLOV GTON, DC	V STREET NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	Continued From pay approximately 2:05 resident stayed horr per week. When inc he indicated that the "stronger" since his May 2011. The staff did not use the whee participated in a star On October 26, 2011 Resident #1's physic dated May 16, 2011, (as modified and acc team) which stated " stand at least three r awake." Minutes late program plan (IPP) of a program objective will stand with physic minutes every hour t months at 100% acc resident's data sheet approximately 10:35 had not documented program on October On October 26, 2011 interview with the dire assigned to Resident October 24, 2011, sh did not stand on the r and October 25, 201- been observed imple October 24, 2011 or of The staff failed to pro opportunity to particip every hour during wal- with his IPP.	p.m., staff indicated he from day program quiry was made to the resident was getting release from the hos f further stated the re- elchair "all" the time a hding program. 1, at 10:00 a.m., revi cal therapy (PT) asse , revealed a recomm cepted by the interdis- instruct <resident's r<br="">minutes every hour the er, review of the indivi- dated June 7, 2011, r which stated "[the re- cal assistance for at I hat he is awake for the uracy." Review of the con October 26, 201 a.m., revealed that the performance data for 25, 2011. , at 9:00 a.m., in an ect support staff who c#1 on the morning of e confirmed that the morning of October 2 1. Staff, however, ha menting the program October 25, 2011. vide Resident #1 the ate in his standing p</resident's>	two days e staff, pital in esident and he ew of essment endation sciplinary mame> to nat he is vidual revealed sident] east 2 hree e 1, at he staff resident 4, 2011 ad not on	1 422	I 422 All Direct Support Staff an residential House Manger h been trained on implementa of Individual Program Plan (IPPs) of all residents. Once weekly, the facility's (and House Manager will ob staff during implementation IPPs to ensure that all progr plans are implemented as outlined. Comprehensive Care will institute, beginning December 2011, monthly meetings betw LPN, RN, QIDP, and resider management staff to discuss, among other agenda items, t implementation of IPPs by st	ation ation s QIDP serve of ram er, veen ntial , he	·D2.11
e	every hour during wal with his IPP.	king hours, in accord	ance				

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING HFD03-0127 B. WING			- COMI	E SURVEY PLETED 1 /26/2011
AME OF PROVIDER OR SUPPLIER		STREET ADDRESS	, CITY, STATE, ZIP CODE	10	20/2011
			LOW STREET NW		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I	EUL DO	D PROVIDER'S PLAN OF C	ORRECTION	(X5) COMPLET
TAG REGULATORY OR LS	SC IDENTIFYING INFORMA		AG I 470		DATE
470 Continued From page	ne 16	147	The LPN #1 has been r		<u></u>
1 470 3522.1 MEDICATIO	-	147	immediately.		:
		1	All LPNs working with	1	
Drugs shall be admi	inistered as set forth	in the	Comprehensive Care I	l, Inc. will be	4
Medications to Pers	ployees to Administer	er l	trained on medication administration guidelin		
Other Developmenta	al Disabilities Act of 1	994	among other topics: em		
D.C. Code, sec. 21-	1201 et seq.		the LPNs are the only a	uthorize	
This Statute is and		Ţ	staff to administer med	ications.	
This Statute is not n Based on observatio	net as evidenced by:	Inconst	Direct Support Staff ha	ve been	
review, the group ho	me for persons with	recora	advised not to participa	te in direct	'
intellectual disabilitie	s (GHPID) failed to e	nsure	participation of medica	tion	
that all drugs were a	dministered as set fo	rth in	administration. Agency		н
DC Code, 22-6100, 1 of the facility. (Resid	for one of the four res	sidents	nursing staff will attend		
or the facility. (Resid	ient #4)		mandatory orientation include medication adm	which will	
The finding includes:		ļ	with sub-sections on me		
		Í	storage, MAR and nurs		
The morning medica	tion administration pa	ass was	documentation. The su		* +
observed on October a.m. At 8:30 a.m., Li	r 24, 2011, beginning PN #1 began properi	at 8:12	RN and the Agency DO	N will	
Resident #4's medica	ations. At 8:34 a m	the I PN	assume oversight respon	nsibility to	
informed the surveyo	or that it was difficult t	o I	ensure that medication	integrity is	
administer the reside	nt his medications.	The	being maintained. In ac		
LPN then handed the	e medication cup to a	direct	med-pass nurse will be a		-
support staff who sub medications with wat	er At no time was U	rea ine DNI #1	least quarterly administ medication and treatme		
observed to attempt t	to administer the resi	dent his	individuals. Special atte		1
medications.			be paid to medication		
Mhon inter income to a		1	administration techniqu	es and	
When interviewed aft administration, the di	er the medication		documentation.		i
she was not a trained	medication employe		The supervisory RN and	the DON	
(TME). Concurrent ir	nterviews with LPN #	1 and	will assume LPN oversig	ght 👘	
qualified intellectual d	lisabilities profession	alon	responsibilities and all n	ned-pass	
October 24, 2011, at :	approximately 10:15	a.m.,	LPN's will be observed		1
revealed the facility di used licensed nurses	a not use TMEs; the	y only	administering medicatio		1
medications.	to automister resider	115	every 3 months. All obs will be documented in th		+ •
· · · · · · · · · · · · · · · · · · ·			и и и и и и и и и и и и и и и и и и и	e	11:30.1

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Health Regulation & Licensing Administration

AND PLAN OF CORRECTION	HFD03-0127 A. BUILDING		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY,	STATE, ZIP CODE	10/20/2011
		1329 LONGFELLOW WASHINGTON, DC 2	STREET NW 0011	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL ODEEN	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETI
 1470 Continued From page Review of the facility October 25, 2011, b confirmed that the facility October 25, 2011, b confirmed that the facility october 25, 2011, b confirmed that the facility staff who was obser #4 his medications w access to the reside The GHPID failed to personnel administe 1500 3523.1 RESIDENT'S Each GHMRP reside that the rights of resi protected in accorda chapter, and other an laws. 	y's personnel records eginning at 10:00 a.r acility was without an erefore, the direct sup ved administering Re vas not authorized to nt's medications. ensure that only lice red residents' medica B RIGHTS ence director shall en dents are observed a nce with D.C. Law 2-	m., pport esident b have ensed ations. I 500 nsure and -137. this		
This Statute is not m Based on observation review, the group hor intellectual disabilities and protect residents Title 7, Chapter 13 of called D.C. Law 2-13 Chapter 19) and fede Sub-Part 1 (for Interm Persons with Mental I two residents in the s The findings include: 1. [§483.420(a)(5) an placed Resident #1's jeopardy by failing to n accordance with phys	ns, interviews and re me for persons with s (GHPID) failed to o ' rights in accordance the D.C. Code (form 7, D.C. Code, Title 6 ral regulations 42 CF nediate Care Facilitie Retardation), for one ample. (Resident #1 of 483.460] The GHF health and safety in manage his diabetes	bserve e with herly FR 483 es for of the I) PID		

PRINTED:	11/10/201
FORM A	APPROVED

Health Regulation & Licens	ing Administration	_			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0127	R/CLIA MBER:	(X2) MULT A. BUILDII B. WING	NG	DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER	<u> </u>	STREET ADD			10/26/2011
COMP CARE II			FELLOW	STATE, ZIP CODE STREET NW 20011	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETE ATE DATE
survey. Residents already eaten their seated at the dining Interview with a din all four residents ha now awaiting the m further indicated tha typically arrived bet A licensed practical 8:10 a.m. and bega medications at 8:12 Resident #1's bedro intellectual disabilitie informed him that th GHPID for their day to the GHPID at 8:5 administered Reside at 9:00 a.m. The LF glucose finger stick he administered 6 u resident's right arm. On October 24, 201 Resident #1's physic the period May 4, 20 diagnosis of insulin for which he had the 100U/ML, inject 5 ur meal for diabetes" a mealtimes and cove follows: 200-250: 1 units of Novolog; 30 and within 350 and 4	n the GHPID to initiate #2 and #3 stated that breakfast. Resident a groom table, wearing ect support staff revea ad finished breakfast a bredication nurse's arriv at the medication nurse ween 7:30 a.m 8:00 I nurse #1 (LPN #1) arrive means and the medication nurse ween 7:30 a.m 8:00 I nurse #1 (LPN #1) arrive ca.m. When LPN #1 born, at 8:46 a.m., the es professional (QIDP the four residents had I programs. The van r 9 a.m. and LPN #1 ent #1's medications to PN then performed a to (reading was 346) after nits of Novolog into the 1, at 11:11 a.m., revie cian's order sheets (PO 011- October 2011, revie 010 (PO 010 (PO 010 (PO 010 (PO 010 (PO 010 (PO 010 (PO 010 (P	e the they had #1 was a bib. aled that and were val. She be a.m. rrived at ents' went into qualified y) eft the returned blood er which re er which re er which re a.m. ovolog ith each at s sources action ovolog ith each at s sources action	1 500	I 500, 1a The nurse in question has been relieved of his duties with Comprehensive Care II, Inc. The facility's RN will ensure that all nursing and direct support staff are trained in diabetic management/care to include individual-specific training, medication management, Physician /RN notification, documentation, and diabetic protocol as specified on Client#1's Physician's Order Sheet (POS). Emphasis of the training will be administration of insulin as specified on Client#1's POS. The supervisory RN and the DON will assume LPN oversigh responsibilities and all med-pas LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.	t

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0127 10/26/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1329 LONGFELLOW STREET NW** COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1 500 Continued From page 19 J 500 Resident #1. He further stated that he usually arrived at the GHPID at 7:30 a.m.; however, he was running late that morning (October 24, 2011). The GHPID failed to ensure Resident #1 received I 500, 1b blood glucose finger sticks in accordance with his The nurse in question has been POS. relieved of his duties with Comprehensive Care II, Inc. b. Resident #1's POS included: "Novolog 100U/ML, inject 5 units subcutaneously with each meal for diabetes" and "Check finger stick at The facility's RN will ensure mealtimes and cover with a sliding scale as that all nursing and direct follows: 200-250: 1 unit of Novolog; 250-300: 4 support staff are trained in units of Novolog; 301-350: 6 units of Novolog; diabetic management/care to and within 350 and 400: 8 units of Novolog." As include individual-specific noted above, Resident #1 was not administered 5 units of Novolog prior to eating breakfast on training, medication October 24, 2011. management, Physician /RN notification, When interviewed on October 24, 2011, at 11:35 documentation, and adhering to a.m., LPN #1 stated that the GHPID's nurses had not been administering Novolog 5 units at diabetic protocol as specified on mealtimes. The LPN interview and review of Client#1's Physician's Order Resident #1's POS revealed the resident had Sheet (POS). Emphasis of the been readmitted to the GHPID with those orders training will be administration on May 4, 2011, after an extended hospital stay. In addition, on October 24, 2011, at 11:40 a.m., of insulin as specified on review of Resident #1's medication administration Client#1's POS. records (MARs) for the period May 24, 2011 through October 23, 2011, revealed no evidence The supervisory RN and the that the resident had received Novolog 5 units DON will assume LPN oversight with every meal. responsibilities and all med-pass The GHPID failed to ensure Resident #1 received LPN's will be observed 5 units of insulin at every meal, in accordance administering medication at with his POS. least every 3 months. All observations will be documented This is a repeat deficiency. See Licensure Deficiency Report dated October 29, 2010 in the employee's file record. 11.30.11 Citations 1293 and 1474.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING B. WING HFD03-0127 10/26/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1329 LONGFELLOW STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION íD (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1500 Continued From page 20 1500 I 500, 1c c. The GHPID failed to provide oversight of The nurse in question has been nursing services to ensure Resident #1's POS relieved of his duties with were being implemented, as follows: **Comprehensive Care II. Inc.** As already indicated above, Resident #1 and his peers ate breakfast before the morning The facility's RN will ensure medication nurse arrived at 8:10 a.m. The that all nursing and direct resident's blood glucose level was not checked support staff are trained in prior to breakfast and he was not administered 5 diabetic management/care to units of insulin at meal time, as ordered by the include individual-specific physician. The LPN acknowledged that the resident did not routinely receive 5 units of insulin training, medication with every meal, and review of Resident #1's management, MARs supported the LPN's statement. Physician /RN notification, documentation, and diabetic Review of Resident #1's medical record on protocol as specified on October 25, 2011, at approximately 1:05 p.m., revealed a Diabetic Clinic consult form dated Client#1's Physician Order August 30, 2011 that reflected the following: "not Sheets (POS). Emphasis of the enough fasting sugar readings ... no changes will training will be administration be made to his insulin at this time because there of insulin at every meal as was not enough pre-meal blood glucose reading. Patient should return in 2-4 weeks with a log of specified on Client#1's POS. his fasting sugar levels before each meal and I will suggest any needed changes ... " The primary The QIDP will on a monthly care physician (PCP) had initialed the consult basis conduct oversight of form on September 2, 2011. medication administration to Interview with the QIDP on October 24, 2011, at ensure that nursing staff are 11:50 a.m., revealed that it was his understanding adhering to physician's orders. that Resident #1 received 5 units of Novolog with each meal and then additional insulin in The RN/Director of Nursing will accordance with the sliding scale, as written maintain direct oversight for the above. There was no evidence that the QIDP had been monitoring Resident #1's meal times, delivery of nursing services by blood glucose testing and/or the administration of licensed practical nursing staff. 1.30.11 insulin by the nursing team. On October 25, 2011, at 1:04 p.m., the registered

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
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	nurse (RN) verified a #1's POS read as w stated that best nurs blood glucose finger hour prior to meals. an RN had been mo times, blood glucose administration of ins medication nurses/L	ritten above. She fu sing practices would sticks be done up to There was no evide phitoring Resident #1 testing and/or the ulin by the team of	rther indicate o one ence that				
	Review of Resident is sticks documentation through October 201 11:31 a.m., revealed documenting blood g times per day (7:00 a p.m.). Interview with staff, however, had r been arriving betwee addition, LPN #1 stat been conducting bloo bedtime, even thoug by the endocrinologis signed-off by the PCI October 25, 2011, at RN examined Reside glucose finger stick of did not represent the administered the fing	n for the period May 11, on October 25, 2 1 that the nursing sta glucose finger sticks a.m., 1:00 p.m., and 1 LPN #1 and direct s evealed that the LPI en 7:30 a.m. and 8:0 ted that nursing staff of glucose finger stic h it had been recom- st on August 30, 201 P on September 2, 2 approximately 1:20 ent # 1's October 20 thart and stated the exact times the LPN	2011 011, at ff were three 8:00 support N had 0 a.m. In had not cks at mended 1 and 011. On p.m., the 11 blood entries				
	It should be noted the until the GHPID put s removing the immedi	systems in place, the	ed onsite reby,				
	It should be further no deficiency. See Licer dated October 29, 20	nsure Deficiency Rei	peat port				÷
	2. [§483.460(k)(2)] Th Resident #1 received	ne GHPID failed to e his prescribed medi	nsure cations				

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on October 24, 20 Resident #1 rece Tegretol, Acetazo Amlopidine, Rispo Calcium Carbona Multi-Delyn, Dorz same day, at 11." medication admir current POS date Nasonex Nasal S were ordered, bu morning medicat In a face to face at 10:18 a.m., the (LPN #1) confirm and Ventolin HF/ administration or 2011. On October 26, 2 Resident #1 was the living room. resident began b while seated. A was present at th "normal" behavio was "calm." Res hard breaths unt the facility at 7:0 residents' medic 8:17 a.m. [Note the aforemention approximately 10 would bring the to day program late	f the medication admin of the provention of the oblamide, Metformin, Col- erdal, Ferrous Sulfate the, Clonidine, Aspirin, olamide and Novolog. 11 a.m., review of the histration record (MAR ad October 2011, reve or pray and Ventolin HF, that not observed during ion pass. interview on October 2 e licensed practical nu- red that Nasonex nase A inhaler were omitted the morning of October 2011, beginning at 6:2 observed seated in a At approximately 6:45 reathing rapidly and we direct support staff pene time stated that this or but sometimes the r sident #1 continued the il 6:50 a.m. LPN #2 a 8 a.m. and administer ations. LPN #2 a 8 a.m. LPN #2 a 8 a.m. LPN #2 a 8 a.m. LPN #2 a 8 a.m. and administer ations. LPN #2 a 8 a.m. LPN #2 the check observations, at 0:15 a.m., LPN #2 star resident's Ventolin inh er that morning and for that he had Ventolin	ealed Bicarb, ogentin, , Toprol, . On the resident's R) and aled that A inhaler the 24, 2011, Irse #1 al spray I from ber 24, 7 a.m., chair in a.m., the with force reson who s was resident e short, irrived to ed the four e facility at cription of ted that she aler to his illow-up with	1500	I 500, 2a All LPNs will undergo norientation. The orientation orientation. The orientation consist of both theoretical for practice as well as a non practical application concentrating on common disease/illness identificate medication administration health and wellness tool developed and used as a for ensuring that care an services are rendered act to developmental disabilinursing standards. The orientation will be documented in the LPN employment file. The supervisory RN and DON will assume LPN or responsibilities and all nursing medication and an anistering medication in the employee's file/responsibilities will be documented in the documented in the documented and ministering medication and an anistering medication and anistering medication anistering and anistering and anistering and anistering a	tion will al basis module on tion and on. A will be basis nd cording lity 's d the oversight med-pass on at all cumented	11-30-

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presented Bicarbonat and the oth administrat for 8 a.m." pack of So Resident # registered October 26 stated that reflect the 3 noon admir and the noo weekends. and medica Resident # Bicarbonate POS. 2) On Octob review of R revealed the spray, instill day." Conc 2011, MAR initials on th administere throughout t process, ho	er 26, 201 two bliste e. One f her was r she furt dium Bic 1's day p nurse (R , 2011, b there she 3 adminis bistration Upon re ations on 1 had not e 4 times ber 26, 2 esident # e physicia I one spra urrent re revealed the morn wever, fa	In at 9:42 a.m., LPN er packs of Sodium had been labeled "be not marked with an . LPN #2 stated "this ther stated that a third arbonate had been s rogram. The facility N) was interviewed of beginning at 12:30 p.f ould be 6 blister pack strations in the home at day program on v istration in the home site, the RN concurr t been receiving the 3 daily, in accordance 011, beginning at 8:3 f1's POS dated Octo an ordered "Nasoney ay in each nostril twice view of the resident's t that LPN #2 had platent as if she had sal spray. Observation ing medication admin accordance with Resident's factor and the factor of the factor of the factor of the sal spray. Observation of the factor of the factor of the sal spray. Observation of the factor of the factor of the sal spray. Observation of the factor of the factor of the sal spray. Observation of the factor of the factor of the sal spray. Observation of the factor of the factor of the sal spray. Observation of the factor of the facto	edtime" one is d blister eent to s m. She cs total, to , the veekdays on ntation ed that Sodium with his 80 a.m., ber 2011, c nasal ce a S October aced her ons nistration	1 500	I 500, 2b(2) LPN #2 has been in-serviced of medication administration regimen and documentation. All LPNs will undergo nursing orientation. The orientation we consist of both theoretical bass for practice as well as a modu on practical application, concentrating on medication administration, and documentation. A health and wellness tool will be developed and used as a basis for ensuring that care and services are rendered according to Physician's Orders and developmental disability nursis standards. The supervisory RN and the DON will assume LPN oversigg responsibilities and all med-pa LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.	g vill is le l ng ht ss		