STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING _____ B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from October 24, 2011 through October 26, 2011. A sample of two clients was selected from a population of four men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process; however, due to concerns in the area of diabetes management, the process was extended on October 25, 2011, at 11:05 a.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Health Care Services.

The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

As a result of the extended survey in Health Care Services, the State Agency (SA) determined that the facility: (1) failed to ensure that an effective system had been developed and implemented to make certain that Client #1's blood glucose levels were tested while fasting; and, (2) failed to ensure that Client #1 received insulin injections as prescribed to ensure his health and safety. The facility's practices, therefore, posed likely harm to Client #1. On October 25, 2011, at 1:05 p.m., the facility's administrator was notified of the immediate jeopardy.

On October 25, 2011, at approximately 5:00 p.m. the facility's administrative assistant and their director of nursing emailed to the SA a plan of correction (POC) to address the immediate jeopardy. The SA survey team met onsite with the facility's administrative assistant and the

Recevd 11/29/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DC Rodwell Buckley	Administrator	11/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1	W 000		

director of nursing (DON) from approximately 5:12 p.m. to 5:26 p.m. The administrative assistant and the DON agreed to supplement the proposed corrective plan by adding measures to be implemented immediately that evening, before dinner. An amended POC was presented at approximately 6:50 p.m. Compliance and implementation of the corrected actions were observed prior to the removal of the immediate jeopardy.

The following was the plan submitted by the facility that outlined the proposed corrective measures:

1. The registered nurse (RN) will review Client #1's physician's orders (POS), medication/treatment, consult and tracking forms, Medication Administration Records (MARs), health passport and health management care plan for accuracy and completeness.

2. The RN will ensure that all nursing and direct care staff are trained in diabetic management/care. All nursing staff will receive diabetic training by October 26, 2011, to include: individual-specific training, medication management, physician/RN notification, documentation, and Comprehensive Care diabetic protocol driven by POS.

3. The RN will ensure all medical appointments are scheduled and completed. Consult orders will be forwarded to the primary care physician (PCP) for review. All verbal orders will be forwarded to the PCP for review/signature within 24 hours or the next business day.

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W 000	Continued From page 2	W 000		

4. The onsite nurse will contact the RN with a verbal/written report and will file the consult form in the appropriate section of the medical book. The RN will be notified of all abnormal findings. The RN will ensure all new orders are posted on the MARs and POS. All POS will be reviewed by the onsite nurse after each appointment. The POS will be forwarded to the pharmacy and posted on the MAR/POS by the onsite nurse.

5. The onsite nurse will document in a progress note all activities and will inform the medication pass nurse of any changes. All nursing staff will review all POS prior to medication administration. Discrepancies/abnormal findings will be brought to the attention of the RN and PCP for review and clarification.

6. Comprehensive Care II will ensure that the facility is properly staffed for medication administration. The RN will be notified if proper staffing is not available.

7. The RN will observe the licensed practical nurse (LPN) and medication pass nurse at least every 3 months.

8. The PCP will receive a copy of all pertinent tracking/observation information with each visit.

The addendum submitted at approximately 6:50 p.m. outlined the following:

1. The PCP was telephoned for finger stick and insulin clarification. Current orders read finger stick prior to each meal and bedtime written by endocrinologist at last appointment (8/30/11, which the PCP had reviewed and confirmed).

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W 000	Continued From page 3 The PCP returned the call at 5:45 p.m. The RN reviewed with the PCP the orders from hospital discharge of 2/2011, follow-up visit 7/2011 and endocrinologist 8/2011. New telephone order to read: finger stick prior to each meal and before bedtime. Sliding scale to be administered based on finger stick results. If client eats hold finger stick. RN will fax verbal orders to PCP for his review and signature. 2. The RN observed <LPN #1> complete finger stick check at 5:47 p.m.; results 115. No observed signs/symptoms of hypo/hyperglycemia. Client #1 was able to then eat with his housemates. 3. Verbal report given to <LPN #1> regarding written orders on POS/MAR. 4. LPN #1 has been removed from the schedule effective immediately. Another medication pass nurse has been assigned medication administration/treatment (including Client #1's FS and insulin injection). [Note: LPN #2 was observed administering the client's finger stick and insulin on the following morning.] 5. Telephone order (TO) posted and placed in medication orders section of POS and posted on MAR. The TO was further clarified the next morning as follows: "Hold finger stick for 2 hours if individual eats and check blood glucose thereafter."	W 000		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative	W 156		

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W 156	Continued From page 4 or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all investigations were completed within five working days of the incident to ensure the health and safety, for one of two sampled clients. (Client #1) The finding includes: Record review on October 25, 2011, at approximately 10:10 a.m., revealed Client #1 was taken to the local hospital on January 18, 2011, for emergent care due to elevated blood glucose levels (375 mg/dl) and a swollen face. According to the incident report, the right side of Client #1's face was swollen and his blood sugar levels were taken at 8:00 p.m. Further record review revealed the facility completed their investigation into this incident on February 5, 2011. Interview with the facility's qualified intellectual disability professional (QIDP) and house manager (HM) on October 25, 2011, at approximately 3:00 p.m., confirmed the incident took place on January 18, 2011, and that the ensuing investigation was completed on February 5, 2011.	W 156	**W156** **Comprehensive Care II Inc. will develop a Policy and Procedure that addresses State reporting requirements. Said policy will include names/position and contact information of all Agency personnel to be notified related to incident reporting as well as the results of any investigation undertaken by Agency staff. Said policy will also include appropriate and required incident and investigation completion time frames. All personnel, including administrative staff, will be in-serviced on above-reference policy and procedure, and a Quality Assurance (QA) administrator will be tasked to ensure compliance.**	12.03.11
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 5	W 159	**W159 (1a)**	

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) integrated, coordinated and monitored services, for two of the two clients in the sample. (Clients #1 and #2)

The findings include:

1. On October 26, 2011, at 11:30 a.m., interview with Client #2's day program case manager revealed that on October 10, 2011, the client became aggressive shortly after his arrival that morning. The client attempted to hit someone. After his one-to-one staff recommended that he return home, the facility van returned and drove the client home. Client #2 did not return to day program for the next two weeks, as recommended by the psychiatrist.

a. Further interview revealed that Client #2's day program had sought in-service training for their staff from the residential psychologist. The day program case manager presented documentation of requests made to the QIDP at the client's Individual Support Plan (ISP) meeting held June 7, 2011, and another request made on September 29, 2011. The QIDP reportedly declined her requests for training day program staff.

On October 25, 2011, at approximately 10:00 a.m., review of Client #2's ISP, dated June 7, 2011, revealed the following: "The residential QMRP and supervisory staff are responsible for ensuring that all who work with <client's name> are trained to implement the behavior support plan." At 11:19 a.m., review of the client's Activity

W159 (1a)

Client #2's day program staff will be trained on November 29, 2011 by the psychologist of the residential facility.

Comprehensive Care will develop a Policy and Procedure 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 continued support of the client's/individual's care or service goals.

12.03.11

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Schedule, dated June 7, 2011, revealed the following: "Support provided by day program staff' while at the day program.

When the QIDP was interviewed on October 26, 2011, at 3:50 p.m., he confirmed that Client #2's day program had requested in-service training for their staff. He stated that because Client #2 resides in an ICF/ID, the day program was responsible for developing and implementing a behavior support plan (BSP) and training their staff.

b. During the interview with Client #2's day program case manager on October 26, 2011, at 11:35 a.m., she stated that the client could become "extremely violent" and his one-to-one staff was assigned to ensure his safety and that of others.

On October 24, 2011, at 2:15 p.m., review of Client #2's BSP revealed the following: "The trained one-to-one staff should use only the least restrictive crisis prevention procedures approved by the DDS in order to secure the safety of <client's name> and that of others."

Personnel records and staff in-service training records were reviewed on October 25, 2011, beginning at 2:00 p.m. There were certifications cards on file documenting that Staff #1 and #2, both of whom were assigned to work with Client #2 as his one-to-one, had received said training in the past. The cards, however, indicated the training had expired July 7, 2011.

On October 26, 2011, at 4:05 p.m., interview the facility's administrative assistant revealed that she

W159 (1b)

Client #2's staff (Staff #1 and #2) have been scheduled to attend a refresher course on Crises Prevention and Intervention (CPI) techniques on December 9, 2011 and December 12, 2011. Other facility staff will receive such training on the above-mentioned days.

12.09.11
12.12.11

The administrative assistant in consonance with the QIDP will on a monthly basis review all personnel records to ensure that training records and other certification requirements are updated timely.

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W 159	Continued From page 7	W 159	**W159, 2** **Comprehensive Care will develop a Policy and Procedure related to Individual Service Coordination and Communication. This policy will outline the procedure for coordination and collaboration with Interdisciplinary Team (IDT) and other support program providers.** **The policy will address timely notification of IDT with emphasis to notifying the psychiatrist of abnormal lab values and/or recommendations from other members of the support team.** **Once monthly, the facility's QIDP and RN will review all medical records to ensure that abnormal lab values and recommendations from consults are communicated to the psychiatrist and other members of the support team for all clients being supported.**	12.03.11

was aware of the training need and she stated that CPI training had not yet been scheduled.

There was no evidence that the QIDP ensured that all staff who work with Client #2 were trained on the client's behavior support needs.

2. On October 24, 2011, Client #2 was administered Depakote, Risperdal, Cogentin and Haloperidol at 8:12 a.m. Review of the client's medical chart on October 24, 2011, at 3:45 p.m., revealed a lab report dated February 15, 2011, that reflected a high serum prolactin level of 60.60 ng/ml (reference range 2.5 - 17.0 ng/ml). [Note: Other lab reports dated May 24, 2010 and May 19, 2011, did not reflect prolactin testing.] On October 25, 2011, at 11:50 a.m., review of the client's psychiatric records revealed no evidence that the prescribing psychiatrist and others participating on the client's Psychotropic Medication Review team were made aware of the abnormal prolactin level reading from February 15, 2011.

On October 26, 2011, at 12:41 p.m., the facility's registered nurse (RN) stated "the psychiatrist should see all of the person's labs." At 12:46 p.m., the RN examined Client #2's psychiatric records, including the Psychotropic Medication Review forms, and confirmed the aforementioned findings.

There was no evidence that the QIDP ensured that Client #2's prescribing psychiatrist was made aware of serum lab tests, dated February 15, 2011, showing elevated prolactin levels.

3. The QIDP failed to ensure that Client #1's

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W 159	Continued From page 8 Individual Program Plan (IPP) included training objectives to meet the client's needs as recommended by the interdisciplinary team. [See W227] 4. The QIDP failed to ensure clients received continuous active treatment. [See W249] 5. The QIDP failed to ensure behavior data was documented in accordance with the behavior support plan (BSP). [See W252]	W 159	**W159, 3** **Please see W 227** **W159, 4** **Please see W 249** **W159, 5** **Please see W 252**	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended by the interdisciplinary team, for one of the two clients in the sample. (Client #1) The finding includes: On October 25, 2011, at 11:50 a.m., Client #1 arrived home from a doctor's appointment. The direct care staff was observed placing the client in a chair in the living room. The staff was observed retrieving the remote control and turning on the television. The staff was further observed using the television remote control, flipping through channels, and asking the client if the station was	W 227		

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W 227	Continued From page 9 "okay." Once a channel was pleasing to the client he responded by moving his head in an up and down motion. Review of Client #1's psychology assessment dated June 5, 2011, on October 26, 2011, at 10:31 a.m., revealed a recommendation to develop a program for him to learn how to use a remote control device to turn the television on/off while in a seated position. Review of the IPP dated June 7, 2011, on October 26, 2011, at approximately 11:30 a.m., revealed no evidence of a training program to address the aforementioned recommendation by the psychologist. Interview with the qualified intellectual disabilities professional (QIDP) on October 26, 2011, at 4:15 p.m., revealed that he was not aware of the recommended training objective and therefore no training program had been developed.	W 227	**W227** **A training goal for the use of a 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 facility's QIDP and RN will review habilitation records of all the clients to ensure that recommendations are adhered to as specified.** **Quarterly Audit will be done by the quality assurance person to ensure that all recommendations are implemented as specified.**	11-01-11
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients	W 249		

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W 249	Continued From page 10	W 249		

received continuous active treatment, for one of the two clients in the sample. (Client #1)

The finding includes:

Observations on October 24, 2011, from 7:40 a.m. until 8:55 a.m., revealed Client #1 sitting in a chair at the dining room table. At 9:00 a.m., the client was observed being assisted onto the van and going to day program. Client #1 arrived home from day program at 3:40 p.m. He was observed until 5:40 p.m., during which time he received personal hygiene care and was assisted to the living room. While seated in the living room, he was observed with his feet elevated on an ottoman and had an evening snack while he remained seated. At 5:40 p.m., staff was observed assisting the client to the dining room for dinner. On October 25, 2011, from 12:05 p.m. until 2:00 p.m., Client #1 was observed sitting in the living room watching television with his feet elevated.

In an interview on October 25, 2011, at approximately 2:05 p.m., staff indicated that the client stayed home from day program two days per week. When inquiry was made to the staff, he indicated that the client was getting "stronger" since his release from the hospital in May 2011. The staff further stated the client did not use the wheelchair "all" the time and he participated in a standing program.

On October 26, 2011, at 10:00 a.m., review of Client #1's physical therapy (PT) assessment dated May 16, 2011, revealed a recommendation (as modified and accepted by the interdisciplinary team) which stated "instruct <client's name> to

W249
All Direct Support Staff and residential House Manger have been trained on implementation of Individual Program Plans (IPPs) of all residents.
Once weekly, the facility's QIDP and House Manager will observe staff during implementation of IPPs to ensure that all program plans are implemented as outlined.
Comprehensive Care will institute, beginning December, 2011, monthly meetings between LPN, RN, QIDP, and residential management staff to discuss, among other agenda items, the implementation of IPPs by staff.

11.02.11

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W 249	Continued From page 11 stand at least three minutes every hour that he is awake." Minutes later, review of the individual program plan (IPP) dated June 7, 2011, revealed a program objective which stated "[the client] will stand with physical assistance for at least 2 minutes every hour that he is awake for three months at 100% accuracy." Review of the client's data sheet on October 26, 2011, at approximately 10:35 a.m., revealed that the staff had not documented performance data for that program on October 25, 2011. On October 26, 2011, at 9:00 a.m., in an interview with the direct support staff who was assigned to Client #1 on the morning of October 24, 2011, she confirmed that the client did not participate in the standing program on the morning of October 24, 2011 and October 25, 2011. Staff, however, had not been observed implementing the program on October 24, 2011 or October 25, 2011. The staff failed to provide Client #1 the opportunity to participate in his standing program every hour during waking hours, in accordance with his IPP.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, facility staff failed to document behavior data in	W 252		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 12	W 252		

accordance with the behavior support plan (BSP), for one of the two clients in the sample. (Client #2)

The finding includes:

On October 24, 2011, at 11:40 a.m., interview with Client #2's day program case manager revealed that on October 10, 2011, the client experienced a behavioral incident shortly after his arrival at day program. The client reportedly threatened to hit a peer. Client #2's 1:1 staff reportedly intervened and prevented any physical contact. Further interview with the case manager revealed the 1:1 staff then brought the client to her office and informed her that the client was not well. The residential van returned shortly thereafter and took him home. Client #2 subsequently stayed home from day program for the next two weeks.

Interviews with Client #2's 1:1 staff and the qualified intellectual disabilities professional (QIDP) [October 25, 2011, at 4:00 p.m., and October 26, 2011, at 3:50 p.m., respectively] confirmed the client was brought home on the morning of October 10, 2011, due to his behavioral incident and mental status.

On October 25, 2011, beginning at approximately 9:30 a.m., review of Client #2's BSP, dated June 2, 2011, revealed "physical aggression" was one of four target maladaptive behaviors and "all incidents of the target behavior should be documented on the data sheet provided... on every shift..." At 11:09 a.m., review of the antecedent-behavior-consequences (ABC) form revealed the following definition for

W252
Client #2's day program and residential staff will be trained on Client #2's BSP and behavior data collection. Emphasis will be placed on accurate and consistent data reporting. The facility's House Manager will on a weekly basis monitor staff in implementing the interventions specified in Client #2's BSP and accurate data collection.

11.29.11

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	09G153	A. BUILDING _____ B. WING _____	10/26/2011

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W 252	Continued From page 13 consequences: "Anything and everything that followed the incident; what was said and done by staff in response to the situation; whether the behavior was resolved and if so how long it took." Concurrent review of the ABC form revealed the 1:1 staff documented Client #2 arrived at day program, refused to shake a peer's hand "and tried to hit him. For consequence, the staff wrote: "I intervened and stopped <client's name> from hitting him." There was no evidence the staff documented everything that followed the behavioral incident (i.e. the returned home that morning), in accordance with the BSP.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to: manage diabetes in accordance with physician's orders [See W322]; ensure laboratory studies were obtained as recommended by an endocrinologist [See W326]; provide each client with nursing services in accordance with their needs [See W331]; ensure quarterly review of client's health status [See W336]; ensure all staff received training on signs and symptoms of hyper/hypoglycemia and shortness of breath as recommended to ensure client health and safety [See W342]; ensure that drug regimen reviews were conducted at least quarterly [See W362]; ensure that all prescribed medications were administered in accordance with clients' physician orders [See W368]; ensure clients received	W 318		

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W 318	Continued From page 14 medications without error [See W369]; and to store medications under proper conditions of security [See W381]. The effects of these systemic practices resulted in the failure of the facility to provide health care services.	W 318	**W318** **Please see W322, W326, W331, W336, W342, W362, W368, W369, and W 381.**	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, the facility placed client health and safety in jeopardy by failing to manage diabetes in accordance with physician's orders, for the one client with diabetes out of a two-client sample. (Client #1) The findings include: 1. The facility failed to ensure Client #1 received blood glucose finger sticks in accordance with his physician's order sheets (POS), as follows: On October 24, 2011, at 7:40 a.m., the surveyors arrived in the facility to initiate the survey. Clients #2 and #3 stated that they had already eaten their breakfast. Client #1 was seated at the dining room table, wearing a bib. Interview with a direct support staff revealed that all four clients had finished breakfast and were now awaiting the medication nurse's arrival. She further indicated that the medication nurse typically arrived between 7:30 a.m. - 8:00 a.m.	W 322		

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W 322	Continued From page 15	W 322	**W322, 1** **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 Order Sheet (POS). Emphasis of the training will be administration 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 orders.** **The RN/Director of Nursing will maintain direct oversight for the delivery of nursing services by licensed practical nursing staff.**	11-30-11

A licensed practical nurse #1 (LPN #1) arrived at 8:10 a.m. and began preparing the clients' medications at 8:12 a.m. When LPN #1 went into Client #1's bedroom, at 8:46 a.m., the qualified intellectual disabilities professional (QIDP) informed him that the four clients had left the facility for their day programs. The van returned to the facility at 8:59 a.m. and LPN #1 administered Client #1's medications by mouth at 9:00 a.m. The LPN then performed a blood glucose finger stick (reading was 346) after which he administered 6 units of Novolog into the client's right arm.

On October 24, 2011, at 11:11 a.m., review of Client #1's POS for the period May 4, 2011-October 2011, revealed a diagnosis of insulin-dependent diabetes mellitus for which he had the following orders: " Novolog 100U/ML, inject 5 units subcutaneously with each meal for diabetes" and "Check finger stick at mealtimes and cover with a sliding scale as follows: 200-250: 1 unit of Novolog; 250-300: 4 units of Novolog; 301-350: 6 units of Novolog; and within 350 and 400: 8 units of Novolog."

On October 24, 2011, at 11:35 a.m., in a face to face interview with LPN #1, he indicated that staff had been informed that if the medication nurse was late, they should "still" wait before feeding Client #1. He further stated that he usually arrived at the facility at 7:30 a.m.; however, he was running late that morning (October 24, 2011).

2. The facility failed to ensure Client #1 received 5 units of insulin at every meal, in accordance with his POS, as follows:

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W 322	Continued From page 16	W 322	**W322, 2** **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 adhering to 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.**	11-30-11

Client #1's POS included: "Novolog 100U/ML, inject 5 units subcutaneously with each meal for diabetes" and "Check finger stick at mealtimes and cover with a sliding scale as follows: 200-250: 1 unit of Novolog; 250-300: 4 units of Novolog; 301-350: 6 units of Novolog; and within 350 and 400: 8 units of Novolog." As noted above, Client #1 was not administered 5 units of Novolog prior to eating breakfast on October 24, 2011.

When interviewed on October 24, 2011, at 11:35 a.m., LPN #1 stated that the facility's nurses had not been administering Novolog 5 units at mealtimes. The LPN interview and review of Client #1's POS revealed the client had been readmitted to the facility with those orders on May 4, 2011, after an extended hospital stay. In addition, on October 24, 2011, at 11:40 a.m., review of Client #1's medication administration records (MARs) for the period May 24, 2011 through October 23, 2011, revealed no evidence that the client had received Novolog 5 units with every meal.

3. The facility failed to provide oversight of nursing services to ensure Client #1's POS were being implemented, as follows:

As already indicated above, Client #1 and his peers ate breakfast before the morning medication nurse arrived at 8:10 a.m. The client's blood glucose level was not checked prior to breakfast and he was not administered 5 units of insulin at meal time, as ordered by the physician. The LPN acknowledged that the client did not routinely receive 5 units of insulin with

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W 322	Continued From page 17	W 322	**W322, 3**	11.30.11

every meal, and review of Client #1's MARs supported the LPN's statement.

Review of Client #1's medical record on October 25, 2011, at approximately 1:05 p.m., revealed a Diabetic Clinic consult form dated August 30, 2011 that reflected the following: "not enough fasting sugar readings... no changes will be made to his insulin at this time because there was not enough pre-meal blood glucose reading. Patient should return in 2-4 weeks with a log of his fasting sugar levels before each meal and I will suggest any needed changes..." The primary care physician (PCP) had initialed the consult form on September 2, 2011.

Interview with the QIDP on October 24, 2011, at 11:50 a.m., revealed that it was his understanding that Client #1 received 5 units of Novolog with each meal and then additional insulin in accordance with the sliding scale, as written above. There was no evidence that the QIDP had been monitoring Client #1's meal times, blood glucose testing and/or the administration of insulin by the nursing team.

On October 25, 2011, at 1:04 p.m., the registered nurse (RN) verified and confirmed that Client #1's POS read as written above. She further stated that best nursing practices would indicate blood glucose finger sticks be done up to one hour prior to meals. There was no evidence that an RN had been monitoring Client #1's meal times, blood glucose testing and/or the administration of insulin by the team of medication nurses/LPNs.

Review of Client #1's blood glucose finger sticks documentation for the period May 2011 through

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 Order Sheets (POS). Emphasis of the training will be administration 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 orders.

The RN/Director of Nursing will maintain direct oversight for the delivery of nursing services by licensed practical nursing staff.

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W 322	Continued From page 18 October 2011, on October 25, 2011, at 11:31 a.m., revealed that the nursing staff were documenting blood glucose finger sticks three times per day (7:00 a.m., 1:00 p.m., and 8:00 p.m.). Interview with LPN #1 and direct support staff, however, had revealed that the LPN had been arriving between 7:30 a.m. and 8:00 a.m. In addition, LPN #1 stated that nursing staff had not been conducting blood glucose finger sticks at bedtime, even though it had been recommended by the endocrinologist on August 30, 2011 and signed-off by the PCP on September 2, 2011. On October 25, 2011, at approximately 1:20 p.m., the RN examined Client # 1's October 2011 blood glucose finger stick chart and stated the entries did not represent the exact times the LPNs had administered the finger sticks. It should be noted that surveyors remained onsite until the facility put systems in place, thereby, removing the immediate jeopardy.	W 322		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure laboratory studies were obtained as recommended by an endocrinologist, for one of the two clients in the sample. (Client #2) The finding includes: During the morning medication administration, on	W 326		

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W 326	Continued From page 19 October 24, 2011, at 9:00 a.m., Client #1 was observed receiving a blood glucose fingerstick. Interview with the licensed practical nurse (LPN #1) after the medication administration revealed that the client had a diagnosis of diabetes. On October 24, 2011, at 11:11 a.m., review of the Client #1's October 2011, physician's orders (POS) confirmed that the client had a diagnosis of diabetes mellitus, insulin dependent. Further review of the client's medical record revealed a diabetic clinic (endocrinology) consult dated August 30, 2011. The consult recommended that the client receive HGAIC and anemia laboratory studies. Further review of the consult indicated that the primary care physician (PCP) had initialed and dated the consult sheet on September 2, 2011. Review of laboratory studies dated September 12, 2011, revealed no evidence that the aforementioned studies were obtained on the said date. Interview with the registered nurse (RN) on October 26, 2011, at approximately 4:00 p.m., revealed that when the PCP signed and dated the August 30, 2011 medical consult sheet, he was in agreement with the specialist's recommendation. The RN confirmed that the HGAIC and anemia laboratory studies were not obtained as recommended.	W 326	**W326** **The RN will ensure all medical/lab appointments and physical exams are scheduled and completed. Consult orders will be forwarded to the Primary Care Physician (PCP) for review. All verbal orders will be forwarded to the PCP for reviewing /signature within 24 hours or the next business day.** **The RN will on a weekly basis review all medical consults to ensure that all recommendations and/or follow-ups are adhered to in a timely fashion.**	11-01-11
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interviews and	W 331		

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W 331	Continued From page 20	W 331		

record review, the facility failed to provide each client with nursing services in accordance with their needs, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4)

The findings include:

1. The facility's nursing services failed to ensure that Client #1's received blood glucose finger sticks and received insulin at every meal, in accordance with his physician's orders. [See W322]

2. The facility's nursing services failed to ensure laboratory studies were obtained as recommended by an endocrinologist. [See W326]

3. The facility's nursing services failed to ensure quarterly review of client health status. [See W336]

4. The facility's nursing services failed to ensure all staff received training on signs and symptoms of hyper/hypoglycemia and shortness of breath as recommended to ensure client health and safety. [See W342]

5. The facility's nursing services failed to ensure that drug regimen reviews were conducted at least quarterly. [See W362]

6. The facility's nursing services failed to ensure that all prescribed medications were administered in accordance with clients' physician orders. [See W368]

7. The facility's nursing services failed to ensure

W331, 1
Please refer to W 322

W331, 2
Please refer to W 326

W331, 3
Please refer to W 336

W331, 4
Please refer to W 342

W331, 5
Please refer to W 362

W331, 6
Please refer to W 368

W331, 7
Please refer to W 369

W331, 8
Please refer to W 381

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W 331	Continued From page 21 clients received medications without error. [See W369] 8. The facility's nursing staff failed to store medications under proper conditions of security. [See W381]	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure quarterly review of client health status, for one of two clients in the sample. (Client #1) The finding includes: During the entrance conference on October 24, 2011, at approximately 10:30 a.m., the qualified intellectual disabilities professional (QIDP) revealed that Client #1 had been hospitalized from January 18, 2011 through May 4, 2011. Upon his return to the facility, the client had been assessed by the interdisciplinary team (IDT). On October 24, 2011, beginning at 11:15 a.m., review of Client #1's medical chart revealed a nursing assessment dated June 6, 2011. Further record review revealed no evidence of a quarterly nursing review in since then. Interview with the registered nurse on October 25, 2011, at 1:04 p.m., confirmed that the quarterly assessment	W 336	**W336** **The quarterly report has been completed. A calendar has been put in place to track when nursing quarterlies are due.** **On a quarterly basis, the Quality Assurance (QA) person will audit all habilitation records to ensure that reports are done and filed in a timely manner.** **The Director of Nursing (DON) will review all nursing assessments for completeness, accuracy, and timely submission.**	11-10-11

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W 336	Continued From page 22 had not been completed, as required.	W 336		
W 342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all staff received training on signs and symptoms of hyper/hypoglycemia and shortness of breath as recommended to ensure client health and safety, for one of two clients in the sample. (Client #1) The findings include: 1. Record review on October 25, 2011, at approximately 10:10 a.m. revealed Client #1 was taken to the local hospital on January 18, 2011, for emergent care due to elevated blood glucose levels (375 mg/dl) and a swollen face. Further record review on the same day, at approximately 10:40 a.m., revealed the ensuing investigation, dated February 5, 2011, recommended that all "staff be trained on signs and symptoms of hypo/hyperglycemia by February 18, 2011." A review of the facility's in-service training records on October 25, 2011, at approximately 2:00 p.m., revealed there was no evidence that the staff received training on hypo/hyperglycemia to	W 342	**W342, 1** **All staff have been trained on signs and symptoms of 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 DSP staff 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 to maintain current basic First Aid and CPR certification.**	11-30-11

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W 342	Continued From page 23 ensure Client #1's health and safety. Interview with the facility's qualified intellectual disabilities professional and house manager on October 25, 2011, at approximately 3:30 p.m., confirmed the training was not in the training logs/binder presented to the survey team October 25, 2011. 2. On October 26, 2011, at approximately 6:45 a.m., Client #1 began breathing rapidly and heavily while seated in a chair in the living room. When queried, a direct support staff person who was present at the time stated that this was "normal" behavior. She further indicated that sometimes the client was "calm" but sometimes he breathed in this manner. Client #1 continued breathing rapidly until 6:50 a.m. (approximately 5 minutes). A licensed practical nurse (LPN #2) arrived to the facility at 7:08 a.m., administered the four clients' medications and then left the facility at 8:17 a.m. On October 26, 2011, beginning at 9:15 a.m., review of Client #1's physician's order sheets (POS) dated October 2011, revealed he was prescribed "Ventolin HFA, inhale two puffs by mouth every six hours for shortness of breath and wheezing." The client was not administered the Ventolin inhaler that morning. When interviewed later that day, at approximately 9:35 a.m., LPN #2 stated she would verify whether the Ventolin order was a "PRN, as needed" order. At approximately 10:15 a.m., LPN #2 stated that the primary care physician had instructed her by telephone moments earlier to change the order to "PRN." She then replied "no," when asked if any of the staff had reported Client #1's episode of	W 342	**W342,2** **Comprehensive Care II, Inc., has hired new LPN staff and also the hiring of a new med pass nurse. All LPNs will undergo nursing orientation.** **The orientation will consist of both theoretical basis for practice as well as a module on practical application concentrating on common disease/illness identification and medication administration. A health and wellness tool will be developed and used as a basis for ensuring that care and services are rendered according 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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.**	11.30.11

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	09G153	A. BUILDING _____ B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 342	Continued From page 24 shortness of breath that was observed at 6:45 a.m. that morning. Upon hearing a description of the aforementioned observations, LPN #2 stated that she would bring the client's Ventolin inhaler to his day program later that morning and follow-up with the RN to ensure that he had Ventolin inhalers available at home and at his day program. Review of staff in-service training records on October 25, 2011, beginning at 2:00 p.m., revealed no evidence that staff had received training on Client #1's diagnosis of "shortness of breath and wheezing." The facility failed to ensure all staff received training on Client #1's health conditions as recommended to ensure his health and safety.	W 342		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. During the medication administration observations on October 24, 2011, at 9:00 a.m., Client #1 was administered Diovan, Sodium Bicarbonate, Tegretol, Acetazolamide, Metformin,	W 362		

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W 362	Continued From page 25 Cogentin, Amlopidine, Risperdal, Ferrous Sulfate, Toprol, Calcium Carbonate, Clonidine, Aspirin, Multi-Delyn, Dorzolamide and Novolog. Review of Client #1's physician orders on October 26, 2011, at 10:31 a.m., revealed that the client received the medications to address his diagnoses of hypertension, seizure disorder, anemia, diabetes, glaucoma, and hypertension Record review on October 24, 2011, 1:00 p.m., revealed a pharmacy review for Client #1 dated June 4, 2011. There was no evidence, however, that drug regimen reviews were conducted at least quarterly. Interview with the facility's LPN Coordinator on October 24, 2011, at approximately 1:00 p.m., revealed that Client #1 was hospitalized when the pharmacist made his rounds to the facility in March 2011. The LPN Coordinator confirmed that the pharmacy reviews were not completed as required (quarterly). 2. On October 24, 2011, Client #2 was administered Depakote, Risperdal, Cogentin and Haloperidol at 8:12 a.m. during the morning medication administration. Review of the client's medical chart on October 25, 2011, at 3:59 p.m., revealed the pharmacist had documented reviews of Client #2's medication regimen on January 10, 2011 and June 4, 2011. Pharmacy reviews were not being conducted at least quarterly.	W 362	**W362, 1 & 2** **The facility has contracted with a new pharmacy replacing the previous one.** **The RN/DON will provide oversight to ensure that pharmacy reviews are being done on a quarterly basis. The RN/DON will further ensure that all pharmacy reviews are properly documented in each individual record.**	11.01.11
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

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W 368	Continued From page 26 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all prescribed medications were administered in accordance with clients' physician orders, for one of the two clients in the sample. (Client #2) The findings include: 1. On October 25, 2011, beginning at 11:31 a.m., review of Client #2's Medication Administration Records revealed that during the period January 2011 - October 2011, the client had received intramuscular injections of Haloperidol on the 15th and 30th of each month. Earlier that morning, however, review of the client's physician's order sheets (POS) for the same period revealed he was prescribed Haloperidol 100 mg intramuscular injections every two weeks. During the Exit conference on October 26, 2011, at approximately 5:00 p.m., the registered nurse and the qualified intellectual disabilities professional acknowledged that a twice monthly schedule for intramuscular injections would not address those months in which there were five weeks and, therefore, not ensure that Client #2 received Haloperidol every two weeks, in accordance with the POS. 2. The facility failed to ensure that all medications were administered without error. [See W369]	W 368	**W368, 1** **A schedule will be set up to conform to the bi-weekly administration of Haloperidol so as to be consistent with the physician's orders of administering Haloperidol every two weeks.** **Every two weeks, the RN/DON will review the Medication Administration Records (MARs) to ensure that medication nurses are conforming to the schedule.** **MARs for all the four residents will be reviewed monthly by the RN to ensure compliance with physician's orders.** **W368, 2** **Please refer to W369.**	11.29.11
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are	W 369		

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W 369	Continued From page 27 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received medications without error, for one of the two client in the sample. (Client #1) The findings includes 1. Observation of the medication administration on October 24, 2011, at 9:00 a.m., revealed Client #1 received Diovan, Sodiun Bicarb, Tegretol, Acetazolamide, Metformin, Cogentin, Amlopidine, Risperdal, Ferrous Sulfate, Toprol, Calcium Carbonate, Clonidine, Aspirin, Multi-Delyn, Dorzolamide and Novolog. On the same day, at 11:11 a.m., review of the client's medication administration record (MAR) and current POS dated October 2011, revealed that Nasonex Nasal Spray and Ventolin HFA inhaler were ordered, but not observed during the morning medication pass. In a face to face interview on October 24, 2011, at 10:18 a.m., the licensed practical nurse #1 (LPN #1) confirmed that Nasonex nasal spray and Ventolin HFA inhaler were omitted from administration on the morning of October 24, 2011. On October 26, 2011, beginning at 6:27 a.m., Client #1 was observed seated in a chair in the living room. At approximately 6:45 a.m., the client began breathing rapidly and with force while seated. A direct support staff person who was present at the time stated that this was "normal"	W 369		

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W 369	Continued From page 28	W 369	**W369, 1** **All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module on practical application concentrating on common disease/illness identification and medication administration. A health and wellness tool will be developed and used as a basis for ensuring that care and services are rendered according 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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.**	11-30-11

behavior but sometimes the client was "calm." Client #1 continued the short, hard breaths until 6:50 a.m. LPN #2 arrived to the facility at 7:08 a.m. and administered the four clients' medications. LPN #2 left the facility at 8:17 a.m. [Note: Upon hearing a description of the aforementioned observations, at approximately 10:15 a.m., LPN #2 stated that she would bring the client's Ventolin inhaler to his day program later that morning and follow-up with the RN to ensure that he had Ventolin inhalers available at home and at his day program.]

On October 26, 2011, beginning at 9:15 a.m., review of Client #1's physician's order sheets (POS) dated October 2011, revealed he was prescribed "Ventolin HFA, inhale two puffs by mouth every six hours for shortness of breath and wheezing." The client was not administered the Ventolin inhaler. When interviewed later that morning, at approximately 9:35 a.m., LPN #2 stated she would verify whether the Ventolin order was a "PRN, as needed" order. At approximately 10:15 a.m., LPN #2 stated that the primary care physician had instructed her to change the order to "PRN." Further interview revealed that no staff had reported Client #1's shortness of breath that morning. She then acknowledged that she had not administered Client #1's Ventolin inhaler in accordance with his POS.

2. The morning medication administration was observed on October 26, 2011, beginning at 7:09 a.m. At approximately 7:27 a.m., LPN #2 began preparing Client #1's medications, including Sodium Bicarbonate 650 mg. She poured another 13 medications and vitamin supplements.

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W 369	Continued From page 29	W 369	

At 7:38 a.m., LPN #2 administered Client #1's medications.

a. On October 26, 2011, beginning at 8:30 a.m., review of Client #1's POS dated October 2011, revealed the physician ordered "Sodium Bicarbonate 650 mg tablet 1 tab by mouth every 6 hours for gastritis." Concurrent review of the client's October 2011, Medication Administration Record (MAR) revealed that the designated times for taking the Sodium Bicarbonate were 6 a.m., 12 p.m., 6 p.m. and 12 a.m.

On October 26, 2011, at 9:42 a.m., LPN #2 presented two blister packs of Sodium Bicarbonate. One had been labeled "bedtime" and the other was not marked with an administration time. LPN #2 stated "this one is for 8 a.m." She further stated that a third blister pack of Sodium Bicarbonate had been sent to Client #1's day program. The facility's registered nurse (RN) was interviewed on October 26, 2011, beginning at 12:30 p.m. She stated that there should be 6 blister packs total, to reflect the 3 administrations in the home, the noon administration at day program on weekdays and the noon administration in the home on weekends. Upon reviewing the documentation and medications on site, the RN concurred that Client #1 had not been receiving the Sodium Bicarbonate 4 times daily, in accordance with his POS.

b. On October 26, 2011, beginning at 8:30 a.m., review of Client #1's POS dated October 2011, revealed the physician ordered "Nasonex nasal spray, instill one spray in each nostril twice a day." Concurrent review of the client's October

W369, 2a

The facility's RN will, on a monthly basis compare all Physician's Orders with their corresponding MARs to ensure that transcription of orders are consistent with Physician's Orders Sheets.

All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module on practical application concentrating on common disease/illness identification and medication administration. A health and wellness tool will be developed and used as a basis for ensuring that care and services are rendered according 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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.

11-30-11

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W 369	Continued From page 30 2011, MAR revealed that LPN #2 had placed her initials on the document as if she had administered the nasal spray. Observations throughout the morning medication administration process, however, failed to include administration of the nasal spray in accordance with Client #1's POS.	W 369	**W369, 2b** **LPN #2 has been in-serviced on medication administration regimen.** **All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module on practical application, concentrating on common disease/illness identification, 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 nursing standards.**	11-30-11
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to store medications under proper conditions of security, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. On October 24, 2011, beginning at 8:12 a.m., a licensed practical nurse (LPN #1) was observed administering the clients' morning medications. At 8:21 a.m., the medication cabinet (located in the dining room) was left unlocked, opened and unsecured while the LPN #1 left the dining room and went to the kitchen. Other staff, clients and surveyors remained in the dining room while the medications were unsecured and accessable. After the medication administration, LPN #1 acknowledged that the medications had been left unsecured. 2. On October 24, 2011, at 8:30 a.m., LPN #1 began preparing Client #4's medications. At 8:34	W 381		

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W 381	Continued From page 31 a.m., the LPN informed the surveyor that it was difficult to administer the client his medications, handed the medication cup to a direct support staff who subsequently administered the medications with water. At no time was LPN #1 observed to attempt to administer the client his medications. When interviewed after the medication administration, the direct support staff stated that she was not a trained medication employee (TME). Concurrent interviews with LPN #1 and qualified intellectual disabilities professional on October 24, 2011, at approximately 10:15 a.m., revealed the facility did not use TMEs; they only used licensed nurses to administer clients' medications. Review of the facility's personnel records on October 25, 2011, beginning at 10:00 a.m., confirmed that the facility was without any certified TMEs. Therefore, the direct support staff who was observed administering Client #4 his medications was not authorized to have access to the client's medications. 3. During the morning medication administration on October 24, 2011, at 9:00 a.m., LPN #1 was observed retrieving a jar from the refrigerator. The jar contained three vials of Novolog insulin and three vials of Lantus insulin that were all prescribed for Client #1. Further observation revealed no evidence that the jar had a lock on it. Interview with LPN #1 on October 24, 2011, at 9:10 a.m. revealed that the jar had a lock on it; however, the nurse failed to put the lock on it after administering the medication the night	W 381	**W381,1** **LPN #1 has been relieved of his duties with Comprehensive Care II, Inc.** **All LPNs working with Comprehensive Care II, Inc. will be trained on medication administration guidelines to include among other topics: infection control, securing the medication cabinet, and observing privacy during medication administration.** **The supervisory RN and the DON will assume LPN oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.**	11-30-11

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W 381	Continued From page 32 before. When interviewed further, the LPN acknowledged that all medications should be secured with a lock. When interviewed on October 25, 2011, at approximately 1:00 p.m., the registered nurse stated that all medications should be secured under lock. 4. The morning medication administration was observed on October 26, 2011, beginning at 7:09 a.m. Another LPN (LPN #2) prepared and administered the medications. At 7:42 a.m., LPN #2 walked out of the dining room, leaving the door to the medication cabinet wide open. Staff, clients and surveyors were observed walking and sitting in the dining room at the time. The LPN returned to the dining room approximately 1 1/2 minutes later. Later that morning, at approximately 10:00 a.m., LPN #2 acknowledged that she had left the door to the medicine cabinet open when she went to the bathroom to wash her hands; thereby leaving the four clients' medications unsecured.	W 381	

W381,2
LPN #1 has been relieved of his duties with Comprehensive Care II, Inc.
All LPNs working with Comprehensive Care II, Inc. will be trained on medication administration guidelines to include among other topics: emphasis that the LPNs are the only authorize staff to administer medications. Direct Support Staff have been advised not to participate in direct participation of medication administration. Agency LPN nursing staff will attend a mandatory orientation which will include medication administration with sub-sections on medication storage, MAR and nursing note documentation. The supervisory RN and the Agency DON will assume oversight responsibility to ensure that medication integrity is being maintained. In addition each med-pass nurse will be observed at least quarterly administering medication and treatments to individuals. Special attention will be paid to medication administration techniques and documentation.

11-30-11

W381,3
A lock has been placed on the jar containing the Novolog Insulin and the vials of Lantus.

The RN will conduct monthly inspection of the jar to ensure that it is locked.

11-01-11

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 24, 2011 through October 26, 2011. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home and at two day programs, as well as a review of resident and administrative records, including incident reports. The Health Regulation and Licensing Administration (HRLA) determined that the facility: (1) failed to ensure that an effective system had been developed and implemented to make certain that Resident #1's blood glucose levels were tested while fasting; and, (2) failed to ensure that Resident #1 received insulin injections as prescribed to ensure his health and safety. The facility's practices, therefore, posed likely harm to Resident #1. On October 25, 2011, at 1:05 p.m., the facility's administrator was notified of the immediate jeopardy. On October 25, 2011, at approximately 5:00 p.m. the facility's administrative assistant and their director of nursing emailed to the HRLA a plan of correction (POC) to address the immediate jeopardy. The HRLA survey team met onsite with the facility's administrative assistant and the director of nursing (DON) from approximately 5:12 p.m. to 5:26 p.m. The administrative assistant and the DON agreed to supplement the proposed corrective plan by adding measures to be implemented immediately that evening, before dinner. An amended POC was presented at approximately 6:50 p.m. Compliance and implementation of the corrected actions were	I 000		

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I 000	Continued From page 1 observed prior to the removal of the immediate jeopardy. The following was the plan submitted by the facility that outlined the proposed corrective measures: 1. The registered nurse (RN) will review Resident #1's physician's orders (POS), medication/treatment, consult and tracking forms, Medication Administration Records (MARs), health passport and health management care plan for accuracy and completeness. 2. The RN will ensure that all nursing and direct care staff are trained in diabetic management/care. All nursing staff will receive diabetic training by October 26, 2011, to include: individual-specific training, medication management, physician/RN notification, documentation, and Comprehensive Care diabetic protocol driven by POS. 3. The RN will ensure all medical appointments are scheduled and completed. Consult orders will be forwarded to the primary care physician (PCP) for review. All verbal orders will be forwarded to the PCP for review/signature within 24 hours or the next business day. 4. The onsite nurse will contact the RN with a verbal/written report and will file the consult form in the appropriate section of the medical book. The RN will be notified of all abnormal findings. The RN will ensure all new orders are posted on the MARs and POS. All POS will be reviewed by the onsite nurse after each appointment. The POS will be forwarded to the pharmacy and posted on the MAR/POS by the onsite nurse.	I 000		

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5. The onsite nurse will document in a progress note all activities and will inform the medication pass nurse of any changes. All nursing staff will review all POS prior to medication administration. Discrepancies/abnormal findings will be brought to the attention of the RN and PCP for review and clarification.

6. Comprehensive Care II will ensure that the facility is properly staffed for medication administration. The RN will be notified if proper staffing is not available.

7. The RN will observe the licensed practical nurse (LPN) and medication pass nurse at least every 3 months.

8. The PCP will receive a copy of all pertinent tracking/observation information with each visit.

The addendum submitted at approximately 6:50 p.m. outlined the following:

1. The PCP was telephoned for finger stick and insulin clarification. Current orders read finger stick prior to each meal and bedtime written by endocrinologist at last appointment (8/30/11, which the PCP had reviewed and confirmed). The PCP returned the call at 5:45 p.m. Reviewed orders from hospital discharge of 2/2011, follow-up visit 7/2011 and endocrinologist 9/2011 which the PCP reviewed/confirmed. Telephone order: finger stick prior to each meal and before bedtime. Sliding scale to be administered based on finger stick results. If resident eats hold finger stick. Will fax verbal orders to PCP for his review and confirmation.

2. Observed <LPN #1> complete finger stick check at 5:47 p.m.; results 115. No observed

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I 000	Continued From page 3 signs/symptoms of hypo/hyperglycemia. Resident #1 was able to then eat with his housemates. 3. Verbal report given to <LPN #1> written orders on POS/MAR. 4. LPN #1 has been removed from the schedule effective immediately. Another medication pass nurse has been assigned medication administration/treatment (including Resident #1's FS and insulin injection). 5. Telephone order (TO) posted and placed in medication orders section of POS and posted on MAR. The TO was further clarified the next morning as follows: "Hold finger stick for 2 hours if individual eats and check blood glucose thereafter."	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure its interior was maintained in a manner that ensured the safety of its residents. [Resident #1] The finding includes: Observation on October 24, 2011 beginning at 3:45 p.m. revealed Resident #1 walked with a	I 090		

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I 090	Continued From page 4 very quick shuffled gait. His steps were very small and choppy as he walked. Observation of the environment revealed the floor in the living room and the kitchen were made of different materials and were of different height. The threshold in the doorway between the two surfaces was missing. The gap between the two surfaces was approximately 1-1 ½ inch wide. Interview with the facility's house manager on October 26, 2011 at approximately 10:30 a.m., confirmed this unfinished part of the floor between the two surfaces poses a trip hazard to Resident #1 due to his unsteady shuffled gait.	I 090	**I 090** **The unfinished part of the floor has been fixed.** **Once monthly, the maintenance division and the House Manager will conduct internal and external environmental audit to ensure compliance.**	11-01-11
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the residents' needs, for one of the two residents in the sample. (Resident #2) The findings include: 1. [Cross-refer to I229.1] There was no evidence that the GHPID ensured that all staff who work with Resident #2 were trained on the resident's behavior support needs. 2. [Cross-refer to I229.2] The GHPID failed to ensure that the one-to-one staff assigned to work with Resident #2 had current training and	I 180	**I 180, 1** **Please refer to I 229.1** **I 180, 2** **Please refer to I 229.2**	

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I 180	Continued From page 5	I 180	**I 180, 3** **Comprehensive Care will develop a Policy and Procedure related to Individual Service Coordination and Communication. This policy will outline the procedure for coordination and collaboration with Interdisciplinary Team (IDT) and other support program providers.** **The policy will address timely notification of IDT with emphasis to notifying the psychiatrist of abnormal lab values and/or recommendations from other members of the support team.** **Once monthly, the facility's QIDP and RN will review all medical records to ensure that abnormal lab values and recommendations from consults are communicated to the psychiatrist and other members of the support team for all clients being supported.**	12/03/11

certification in crisis prevention procedures, in accordance with the resident's behavior support plan.

3. On October 24, 2011, Resident #2 was administered Depakote, Risperdal, Cogentin and Haloperidol at 8:12 a.m. Review of the resident's medical chart on October 24, 2011, at 3:45 p.m., revealed a lab report dated February 15, 2011, that reflected a high serum prolactin level of 60.60 ng/ml (reference range 2.5 - 17.0 ng/ml). [Note: Other lab reports dated May 24, 2010 and May 19, 2011 did not reflect prolactin testing.] On October 25, 2011, at 11:50 a.m., review of the resident's psychiatric records revealed no evidence that the prescribing psychiatrist and others participating on the resident's Psychotropic Medication Review team were made aware of the abnormal prolactin level reading from February 15, 2011.

On October 26, 2011, at 12:41 p.m., the facility's registered nurse (RN) stated "the psychiatrist should see all of the person's labs." At 12:46 p.m., the RN examined Resident #2's psychiatric records, including the Psychotropic Medication Review forms, and confirmed the aforementioned findings.

There was no evidence that the GHPID ensured that Resident #2's prescribing psychiatrist was made aware of serum lab tests, dated February 15, 2011, showing elevated prolactin levels.

4. The GHPID failed to ensure that Resident #1's Individual Program Plan (IPP) included training objectives to meet the resident's needs as recommended by the interdisciplinary team. [See I420]

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I 180	Continued From page 6 5. The GHPID failed to ensure residents received continuous active treatment. [See I422] 6. The GHPID failed to ensure behavior data was documented in accordance with the behavior support plan (BSP). [See Federal Deficiency Report - Citation W252]	I 180	**I 180,4** **Please refer to I 420** **I 180,5** **Please refer to I 422** **I 180,6** **Please refer to W252**	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on staff interview and record review, the the group home for persons with intellectual disabilities (GHPID) failed to provide ongoing in-service training for staff on signs and symptoms of hyper/hypoglycemia and shortness of breath as recommended to ensure resident health and safety, for one of two residents in the sample. (Resident #1) The findings include: 1. Record review on October 25, 2011, at approximately 10:10 a.m. revealed Resident #1 was taken to the local hospital on January 18, 2011, for emergent care due to elevated blood glucose levels (375 mg/dl) and a swollen face. Further record review on the same day, at approximately 10:40 a.m., revealed the ensuing investigation, dated February 5, 2011, recommended that all "staff be trained on signs and symptoms of hypo/hyperglycemia by February 18, 2011." A review of the facility's in-service training records on October 25, 2011, at approximately 2:00 p.m., revealed there was no evidence that the staff	I 222	**I 222,1** **All staff have been trained on signs and symptoms of 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 to maintain current basic First Aid and CPR certification.**	11-30-11

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I 222	Continued From page 7 received training on hypo/hyperglycemia to ensure Resident #1's health and safety. Interview with the facility's qualified intellectual disabilities professional and house manager on October 25, 2011, at approximately 3:30 p.m., confirmed the training was not in the training logs/binder presented to the survey team October 25, 2011. 2. On October 26, 2011, at approximately 6:45 a.m., Resident #1 began breathing rapidly and heavily while seated in a chair in the living room. When queried, a direct support staff person who was present at the time stated that this was "normal" behavior. She further indicated that sometimes the resident was "calm" but sometimes he breathed in this manner. Resident #1 continued breathing rapidly until 6:50 a.m. (approximately 5 minutes). A licensed practical nurse (LPN #2) arrived to the facility at 7:08 a.m., administered the four residents' medications and then left the facility at 8:17 a.m. On October 26, 2011, beginning at 9:15 a.m., review of Resident #1's physician's order sheets (POS) dated October 2011, revealed he was prescribed "Ventolin HFA, inhale two puffs by mouth every six hours for shortness of breath and wheezing." The resident was not administered the Ventolin inhaler that morning. When interviewed later that day, at approximately 9:35 a.m., LPN #2 stated she would verify whether the Ventolin order was a "PRN, as needed" order. At approximately 10:15 a.m., LPN #2 stated that the primary care physician had instructed her by telephone moments earlier to change the order to "PRN." She then replied "no," when asked if any of the staff had reported Resident #1's episode of shortness of breath that was observed at 6:45	I 222	**I 222,2** **Please refer to I 222,1**	

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I 222	Continued From page 8 a.m. that morning. Upon hearing a description of the aforementioned observations, LPN #2 stated that she would bring the resident's Ventolin inhaler to his day program later that morning and follow-up with the RN to ensure that he had Ventolin inhalers available at home and at his day program. Review of staff in-service training records on October 25, 2011, beginning at 2:00 p.m., revealed no evidence that staff had received training on Resident #1's diagnosis of "shortness of breath and wheezing." The facility failed to ensure all staff received training on Resident #1's health conditions as recommended to ensure his health and safety.	I 222		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure two (2) of fourteen (14) staff and one (1) of nine (9) consultants failed to have a valid CPR certification on record to ensure the health and safety, for four of four residents of the facility. (Residents #1, #2, #3, and #4) The finding includes:	I 227	**I 227** **Staff #5 and Staff #13 have submitted current CPR and First Aid Certifications.** **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.**	11.29.11

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I 227	Continued From page 9	I 227		

Record review on October 25, 2011, beginning at 11:00 a.m., revealed Staff #5 and Staff #13 failed to have a valid CPR and First Aid certifications on file.

Interview with the facility's house manager on October 26, 2011, at approximately 10:45 a.m., confirmed the above findings and also indicated she would have the oversight corrected immediately by informing the qualified intellectual disabilities professional and the human resources department.

I 229 3510.5(f) STAFF TRAINING — I 229

Each training program shall include, but not be limited to, the following:

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

This Statute is not met as evidenced by:
Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures, for one of the two residents in the sample. (Resident #2)

The findings include:

1. On October 26, 2011, at 11:30 a.m., interview with Resident #2's day program case manager revealed that on October 10, 2011, the resident became aggressive shortly after his arrival that morning. The resident attempted to hit someone.

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I 229	Continued From page 10 After his one-to-one staff recommended that he return home, the facility van returned and drove the resident home. Resident #2 did not return to day program for the next two weeks, as recommended by the psychiatrist. Further interview revealed that Resident #2's day program had sought in-service training for their staff from the residential psychologist. She presented documentation of requests made to the qualified intellectual disabilities professional (QIDP) at the resident's annual Individual Support Plan (ISP) meeting held June 7, 2011, and on September 29, 2011. The QIDP reportedly declined her requests for training the day program staff. On October 25, 2011, at approximately 10:00 a.m., review of Resident #2's ISP, dated June 7, 2011, revealed the following: "The residential QMRP and supervisory staff are responsible for ensuring that all who work with <resident's name> are trained to implement the behavior support plan." At 11:19 a.m., review of the resident's Activity Schedule, dated June 7, 2011, revealed the following: "Support provided by day program staff" while at the day program. When the QIDP was interviewed on October 26, 2011, at 3:50 p.m., he confirmed that Resident #2's day program had requested in-service training for their staff. He stated that because Resident #2 resides in an ICF/ID, the day program was responsible for developing and implementing a behavior support plan (BSP) and training their staff. There was no evidence that the QIDP ensured that all staff who work with Resident #2 were trained on the resident's behavior support needs.	I 229	**I 229, 1** **Client #2's day program staff will be trained on November 29, 2011 by the psychologist of the residential facility.** **Comprehensive Care will develop a Policy and Procedure 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 continued support of the client's/individual's care or service goals.**	11.29.11 12.03.11

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I 229	Continued From page 11 2. [Cross-refer to I229.1] On October 26, 2011, at 11:35 a.m., interview with Resident #2's day program case manager revealed that the resident could become "extremely violent" and had a one-to-one staff assigned to work with him during daytime hours to ensure the safety of Resident #2 and others. On October 24, 2011, at 2:15 p.m., review of Resident #2's BSP revealed the following: "The trained one-to-one staff should use only the least restrictive crisis prevention procedures approved by the DDS in order to secure the safety of <resident's name> and that of others." Personnel records and staff in-service training records were reviewed on October 25, 2011, beginning at 2:00 p.m. There were certifications cards on file documenting that Staff #1 and #2, both of whom were assigned to work with Resident #2 as his one-to-one, had received said training in the past. The cards, however, indicated the certification had expired July 7, 2011. On October 26, 2011, at 4:05 p.m., interview the facility's administrative assistant revealed that she was aware of the training need and she stated that CPI training had not yet been scheduled. There was no evidence that the QIDP ensured that all staff who work with Resident #2 were trained on the resident's behavior support needs.	I 229	**I 229, 2** **Client #2's staff (Staff #1 and #2) have been scheduled to attend a refresher course on Crises Prevention and Intervention (CPI) techniques on December 9, 2011 and December 12, 2011. Other facility staff will receive such training on the above-mentioned days.** **The administrative assistant in consonance with the QIDP will on a monthly basis review all personnel records to ensure that training records and other certification requirements are updated timely.**	12.09.11 12.12.11
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and	I 261		

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I 261	Continued From page 12 review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all personnel records were made available to the survey team for review, for 1 out of 26 personnel. (LPN #1) The finding includes: On October 24, 2011, at approximately 9:30 a.m., the survey team requested the personnel records from the house manager (HM) and the qualified intellectual disabilities professional (QIDP). Both the HM and the QIDP indicated the personnel records were not kept in the home, but were being maintained at the facility's main office. Both the HM and the QIDP indicated all the personnel records would be brought to the home on the following day (October 25, 2011). On October 25, 2011 at 10:45 a.m., the personnel records were provided to the survey team. Review of the personnel records on October 25, 2011, at approximately 1:30 p.m., revealed the personnel record for LPN #1 was not included or available for review. The facility failed to ensure that the personnel record for 1 out of 26 employees was made available for review to ensure compliance with this section.	I 261	**I 261** **This was an oversight.** **A tracking system will be put in place to ensure that all personnel records are presented at a time of review.**	10-30-11
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.	I 420		

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I 420	Continued From page 13	I 420		

This Statute is not met as evidenced by:
Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum level of social functioning, for one of the two residents in the sample. (Resident #1)

The finding includes:

On October 25, 2011, at 11:50 a.m., Resident #1 arrived home from a doctor's appointment. The direct care staff was observed placing the resident in a chair in the living room. The staff was observed retrieving the remote control and turning on the television. The staff was further observed using the television remote control, flipping through channels, and asking the resident if the station was "okay." Once a channel was pleasing to the resident he responded by moving his head in an up and down motion.

Review of Resident #1's psychology assessment dated June 5, 2011, on October 26, 2011, at 10:31 a.m., revealed a recommendation to develop a program for him to learn how to use a remote control device to turn the television on/off while in a seated position.

Review of the individual program plan dated June 7, 2011, on October 26, 2011, at approximately 11:30 a.m., revealed no evidence of a training program to address the aforementioned recommendation by the psychologist.

Interview with the qualified intellectual disabilities professional (QIDP) on October 26, 2011, at 4:15

I 420
A training goal for the use of a 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 facility's QIDP and RN will review habilitation records of all the clients to ensure that recommendations are adhered to as specified.

Quarterly Audit will be done by the quality assurance person to ensure that all recommendations are implemented as specified. 11.01.11

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I 420	Continued From page 14 p.m., revealed that he was not aware of the recommended training objective and therefore no training program had been developed.	I 420		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents received habilitation and assistance as prescribed in their Individual Support Plan, for one of the two residents in the sample. (Resident #1) The findings include: Observations on October 24, 2011, from 7:40 a.m. until 8:55 a.m., revealed Resident #1 sitting in a chair at the dining room table. At 9:00 a.m., the resident was observed being assisted onto the van and going to day program. Resident #1 arrived home from day program at 3:40 p.m. He was observed until 5:40 p.m., during which time he received personal hygiene care and was assisted to the living room. While seated in the living room, he was observed with his feet elevated on an ottoman and had an evening snack while he remained seated. At 5:40 p.m., staff was observed assisting the resident to the dining room for dinner. On October 25, 2011, from 12:05 p.m. until 2:00 p.m., Resident #1 was observed sitting in the living room watching television with his feet elevated. In an interview on October 25, 2011, at	I 422		

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I 422	Continued From page 15	I 422		

approximately 2:05 p.m., staff indicated that the resident stayed home from day program two days per week. When inquiry was made to the staff, he indicated that the resident was getting "stronger" since his release from the hospital in May 2011. The staff further stated the resident did not use the wheelchair "all" the time and he participated in a standing program.

On October 26, 2011, at 10:00 a.m., review of Resident #1's physical therapy (PT) assessment dated May 16, 2011, revealed a recommendation (as modified and accepted by the interdisciplinary team) which stated "instruct <resident's name> to stand at least three minutes every hour that he is awake." Minutes later, review of the individual program plan (IPP) dated June 7, 2011, revealed a program objective which stated "[the resident] will stand with physical assistance for at least 2 minutes every hour that he is awake for three months at 100% accuracy." Review of the resident's data sheet on October 26, 2011, at approximately 10:35 a.m., revealed that the staff had not documented performance data for that program on October 25, 2011.

On October 26, 2011, at 9:00 a.m., in an interview with the direct support staff who was assigned to Resident #1 on the morning of October 24, 2011, she confirmed that the resident did not stand on the morning of October 24, 2011 and October 25, 2011. Staff, however, had not been observed implementing the program on October 24, 2011 or October 25, 2011.

The staff failed to provide Resident #1 the opportunity to participate in his standing program every hour during waking hours, in accordance with his IPP.

I 422
All Direct Support Staff and residential House Manger have been trained on implementation of Individual Program Plans (IPPs) of all residents.
Once weekly, the facility's QIDP and House Manager will observe staff during implementation of IPPs to ensure that all program plans are implemented as outlined.
Comprehensive Care will institute, beginning December, 2011, monthly meetings between LPN, RN, QIDP, and residential management staff to discuss, among other agenda items, the implementation of IPPs by staff. 11.02.11

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I 470	Continued From page 16 3522.1 MEDICATIONS Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all drugs were administered as set forth in DC Code, 22-6100, for one of the four residents of the facility. (Resident #4) The finding includes: The morning medication administration pass was observed on October 24, 2011, beginning at 8:12 a.m. At 8:30 a.m., LPN #1 began preparing Resident #4's medications. At 8:34 a.m., the LPN informed the surveyor that it was difficult to administer the resident his medications. The LPN then handed the medication cup to a direct support staff who subsequently administered the medications with water. At no time was LPN #1 observed to attempt to administer the resident his medications. When interviewed after the medication administration, the direct support staff stated that she was not a trained medication employee (TME). Concurrent interviews with LPN #1 and qualified intellectual disabilities professional on October 24, 2011, at approximately 10:15 a.m., revealed the facility did not use TMEs; they only used licensed nurses to administer residents' medications.	I 470 I 470	**I 470** **The LPN #1 has been removed from the schedule effective immediately.** **All LPNs working with Comprehensive Care II, Inc. will be trained on medication administration guidelines to include among other topics: emphasis that the LPNs are the only authorize staff to administer medications. Direct Support Staff have been advised not to participate in direct participation of medication administration. Agency LPN nursing staff will attend a mandatory orientation which will include medication administration with sub-sections on medication storage, MAR and nursing note documentation. The supervisory RN and the Agency DON will assume oversight responsibility to ensure that medication integrity is being maintained. In addition each med-pass nurse will be observed at least quarterly administering medication and treatments to individuals. Special attention will be paid to medication administration techniques and documentation.** **The supervisory RN and the DON will assume LPN oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.**	11.30.11

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I 470	Continued From page 17 Review of the facility's personnel records on October 25, 2011, beginning at 10:00 a.m., confirmed that the facility was without any certified TMEs. Therefore, the direct support staff who was observed administering Resident #4 his medications was not authorized to have access to the resident's medications. The GHPID failed to ensure that only licensed personnel administered residents' medications.	I 470		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the two residents in the sample. (Resident #1) The findings include: 1. [§483.420(a)(5) and 483.460] The GHPID placed Resident #1's health and safety in jeopardy by failing to manage his diabetes in accordance with physician's orders, as follows: a. On October 24, 2011, at 7:40 a.m., the	I 500		

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I 500	Continued From page 18	I 500		

surveyors arrived in the GHPID to initiate the survey. Residents #2 and #3 stated that they had already eaten their breakfast. Resident #1 was seated at the dining room table, wearing a bib. Interview with a direct support staff revealed that all four residents had finished breakfast and were now awaiting the medication nurse's arrival. She further indicated that the medication nurse typically arrived between 7:30 a.m. - 8:00 a.m.

A licensed practical nurse #1 (LPN #1) arrived at 8:10 a.m. and began preparing the residents' medications at 8:12 a.m. When LPN #1 went into Resident #1's bedroom, at 8:46 a.m., the qualified intellectual disabilities professional (QIDP) informed him that the four residents had left the GHPID for their day programs. The van returned to the GHPID at 8:59 a.m. and LPN #1 administered Resident #1's medications by mouth at 9:00 a.m. The LPN then performed a blood glucose finger stick (reading was 346) after which he administered 6 units of Novolog into the resident's right arm.

On October 24, 2011, at 11:11 a.m., review of Resident #1's physician's order sheets (POS) for the period May 4, 2011- October 2011, revealed a diagnosis of insulin-dependent diabetes mellitus for which he had the following orders: " Novolog 100U/ML, inject 5 units subcutaneously with each meal for diabetes" and "Check finger stick at mealtimes and cover with a sliding scale as follows: 200-250: 1 unit of Novolog; 250-300: 4 units of Novolog; 301-350: 6 units of Novolog; and within 350 and 400: 8 units of Novolog."

On October 24, 2011, at 11:35 a.m., in a face to face interview with LPN #1, he indicated that staff had been informed that if the medication nurse was late, they should "still" wait before feeding

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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record. 11.30.11

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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 blood glucose finger sticks in accordance with his POS.

b. Resident #1's POS included: "Novolog 100U/ML, inject 5 units subcutaneously with each meal for diabetes" and "Check finger stick at mealtimes and cover with a sliding scale as follows: 200-250: 1 unit of Novolog; 250-300: 4 units of Novolog; 301-350: 6 units of Novolog; and within 350 and 400: 8 units of Novolog." As noted above, Resident #1 was not administered 5 units of Novolog prior to eating breakfast on October 24, 2011.

When interviewed on October 24, 2011, at 11:35 a.m., LPN #1 stated that the GHPID's nurses had not been administering Novolog 5 units at mealtimes. The LPN interview and review of Resident #1's POS revealed the resident had been readmitted to the GHPID with those orders on May 4, 2011, after an extended hospital stay. In addition, on October 24, 2011, at 11:40 a.m., review of Resident #1's medication administration records (MARs) for the period May 24, 2011 through October 23, 2011, revealed no evidence that the resident had received Novolog 5 units with every meal.

The GHPID failed to ensure Resident #1 received 5 units of insulin at every meal, in accordance with his POS.

This is a repeat deficiency. See Licensure Deficiency Report dated October 29, 2010 - Citations I293 and I474.

I 500, 1b
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 adhering to 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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.

11.30.11

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I 500	Continued From page 20	I 500	**I 500, 1c** **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 Order Sheets (POS). Emphasis of the training will be administration 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 orders.** **The RN/Director of Nursing will maintain direct oversight for the delivery of nursing services by licensed practical nursing staff.**	11.30.11

c. The GHPID failed to provide oversight of nursing services to ensure Resident #1's POS were being implemented, as follows:

As already indicated above, Resident #1 and his peers ate breakfast before the morning medication nurse arrived at 8:10 a.m. The resident's blood glucose level was not checked prior to breakfast and he was not administered 5 units of insulin at meal time, as ordered by the physician. The LPN acknowledged that the resident did not routinely receive 5 units of insulin with every meal, and review of Resident #1's MARs supported the LPN's statement.

Review of Resident #1's medical record on October 25, 2011, at approximately 1:05 p.m., revealed a Diabetic Clinic consult form dated August 30, 2011 that reflected the following: "not enough fasting sugar readings... no changes will be made to his insulin at this time because there was not enough pre-meal blood glucose reading. Patient should return in 2-4 weeks with a log of his fasting sugar levels before each meal and I will suggest any needed changes..." The primary care physician (PCP) had initialed the consult form on September 2, 2011.

Interview with the QIDP on October 24, 2011, at 11:50 a.m., revealed that it was his understanding that Resident #1 received 5 units of Novolog with each meal and then additional insulin in accordance with the sliding scale, as written above. There was no evidence that the QIDP had been monitoring Resident #1's meal times, blood glucose testing and/or the administration of insulin by the nursing team.

On October 25, 2011, at 1:04 p.m., the registered

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nurse (RN) verified and confirmed that Resident #1's POS read as written above. She further stated that best nursing practices would indicate blood glucose finger sticks be done up to one hour prior to meals. There was no evidence that an RN had been monitoring Resident #1's meal times, blood glucose testing and/or the administration of insulin by the team of medication nurses/LPNs.

Review of Resident #1's blood glucose finger sticks documentation for the period May 2011 through October 2011, on October 25, 2011, at 11:31 a.m., revealed that the nursing staff were documenting blood glucose finger sticks three times per day (7:00 a.m., 1:00 p.m., and 8:00 p.m.). Interview with LPN #1 and direct support staff, however, had revealed that the LPN had been arriving between 7:30 a.m. and 8:00 a.m. In addition, LPN #1 stated that nursing staff had not been conducting blood glucose finger sticks at bedtime, even though it had been recommended by the endocrinologist on August 30, 2011 and signed-off by the PCP on September 2, 2011. On October 25, 2011, at approximately 1:20 p.m., the RN examined Resident # 1's October 2011 blood glucose finger stick chart and stated the entries did not represent the exact times the LPNs had administered the finger sticks.

It should be noted that surveyors remained onsite until the GHPID put systems in place, thereby, removing the immediate jeopardy.

It should be further noted that this is a repeat deficiency. See Licensure Deficiency Report dated October 29, 2010 - Citation I291.2.

2. [§483.460(k)(2)] The GHPID failed to ensure Resident #1 received his prescribed medications

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I 500	Continued From page 22 without error, as follows: a. Observation of the medication administration on October 24, 2011, at 9:00 a.m., revealed Resident #1 received Diovan, Sodiun Bicarb, Tegretol, Acetazolamide, Metformin, Cogentin, Amlopidine, Risperdal, Ferrous Sulfate, Toprol, Calcium Carbonate, Clonidine, Aspirin, Multi-Delyn, Dorzolamide and Novolog. On the same day, at 11:11 a.m., review of the resident's medication administration record (MAR) and current POS dated October 2011, revealed that Nasonex Nasal Spray and Ventolin HFA inhaler were ordered, but not observed during the morning medication pass. In a face to face interview on October 24, 2011, at 10:18 a.m., the licensed practical nurse #1 (LPN #1) confirmed that Nasonex nasal spray and Ventolin HFA inhaler were omitted from administration on the morning of October 24, 2011. On October 26, 2011, beginning at 6:27 a.m., Resident #1 was observed seated in a chair in the living room. At approximately 6:45 a.m., the resident began breathing rapidly and with force while seated. A direct support staff person who was present at the time stated that this was "normal" behavior but sometimes the resident was "calm." Resident #1 continued the short, hard breaths until 6:50 a.m. LPN #2 arrived to the facility at 7:08 a.m. and administered the four residents' medications. LPN #2 left the facility at 8:17 a.m. [Note: Upon hearing a description of the aforementioned observations, at approximately 10:15 a.m., LPN #2 stated that she would bring the resident's Ventolin inhaler to his day program later that morning and follow-up with the RN to ensure that he had Ventolin inhalers	I 500	**I 500, 2a** **All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module on practical application concentrating on common disease/illness identification and medication administration. A health and wellness tool will be developed and used as a basis for ensuring that care and services are rendered according 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 oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file/record.**	11-30-11

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I 500	Continued From page 23 available at home and at his day program.] On October 26, 2011, beginning at 9:15 a.m., review of Resident #1's physician's order sheets (POS) dated October 2011, revealed he was prescribed "Ventolin HFA, inhale two puffs by mouth every six hours for shortness of breath and wheezing." The resident was not administered the Ventolin inhaler. When interviewed later that morning, at approximately 9:35 a.m., LPN #2 stated she would verify whether the Ventolin order was a "PRN, as needed" order. At approximately 10:15 a.m., LPN #2 stated that the primary care physician had instructed her to change the order to "PRN." Further interview revealed that no staff had reported Resident #1's shortness of breath that morning. She then acknowledged that she had not administered Resident #1's Ventolin inhaler in accordance with his POS. b. The morning medication administration was observed on October 26, 2011, beginning at 7:09 a.m. At approximately 7:27 a.m., LPN #2 began preparing Resident #1's medications, including Sodium Bicarbonate 650 mg. She poured another 13 medications and vitamin supplements. At 7:38 a.m., LPN #2 administered Resident #1's medications. 1) On October 26, 2011, beginning at 8:30 a.m., review of Resident #1's POS dated October 2011, revealed the physician ordered "Sodium Bicarbonate 650 mg tablet 1 tab by mouth every 6 hours for gastritis." Concurrent review of the resident's October 2011, Medication Administration Record (MAR) revealed that the designated times for taking the Sodium Bicarbonate were 6 a.m., 12 p.m., 6 p.m. and 12 a.m.	I 500	**I 500, 2b(1)** **LPN #2 has been in-serviced on medication administration regimen.** **All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module on practical application, concentrating on common disease/illness identification, 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 nursing standards.** **The supervisory RN and the DON will assume LPN oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file/record.**	11-30-11

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I 500	Continued From page 24 On October 26, 2011, at 9:42 a.m., LPN #2 presented two blister packs of Sodium Bicarbonate. One had been labeled "bedtime" and the other was not marked with an administration time. LPN #2 stated "this one is for 8 a.m." She further stated that a third blister pack of Sodium Bicarbonate had been sent to Resident #1's day program. The facility's registered nurse (RN) was interviewed on October 26, 2011, beginning at 12:30 p.m. She stated that there should be 6 blister packs total, to reflect the 3 administrations in the home, the noon administration at day program on weekdays and the noon administration in the home on weekends. Upon reviewing the documentation and medications on site, the RN concurred that Resident #1 had not been receiving the Sodium Bicarbonate 4 times daily, in accordance with his POS. 2) On October 26, 2011, beginning at 8:30 a.m., review of Resident #1's POS dated October 2011, revealed the physician ordered "Nasonex nasal spray, instill one spray in each nostril twice a day." Concurrent review of the resident's October 2011, MAR revealed that LPN #2 had placed her initials on the document as if she had administered the nasal spray. Observations throughout the morning medication administration process, however, failed to include administration of the nasal spray in accordance with Resident #1's POS.	I 500	**I 500, 2b(2)** **LPN #2 has been in-serviced on medication administration regimen and documentation. All LPNs will undergo nursing orientation. The orientation will consist of both theoretical basis for practice as well as a module 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 nursing standards.** **The supervisory RN and the DON will assume LPN oversight responsibilities and all med-pass LPN's will be observed administering medication at least every 3 months. All observations will be documented in the employee's file record.**	11-30-11