

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

PRINTED: 04/11/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2008
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NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

On February 23, 2008, the Health Regulation Licensing Administration (HRLA) was notified via facsimile by the Incident Management Coordinator at RCM of Washington, Inc. (Intermediate Care Facility for the Mental Retarded) of the death of Resident #1, who resided at a RCM, Inc. facility located at 1318 45th St., NE. The information received via facsimile indicated that Resident #1 had been hospitalized at Washington Hospital Center with a diagnosis of seizure disorder since January 29, 2008 and died on February 23, 2008.

Based on the above preliminary findings, a surveyor from the HRLA initiated an onsite investigation on February 25, 2008, to determine compliance with federal and local standards of care prior to Resident #1's death. The results of the investigation were based on observations, interviews with the administrative personnel, and the facility's nursing and direct care staff. Also the findings were based on the review of the client's habilitation and medical, and the facility's administrative records; including incident reports. On February 29, 2008, interviews were conducted at the day program with the nursing staff and administrative staff. On March 3, 2008, an interview was conducted with the Primary Care Physician at her medical clinic.

W 102 483.410 GOVERNING BODY AND MANAGEMENT

The facility must ensure that specific governing body and management requirements are met.

W 000

W 102

RECEIVED
 DEPARTMENT OF HEALTH
 HEALTH REGULATION
 ADMINISTRATION
 2008 MAY -9 P 12:50

Angela E. [Signature]

Program Director

5-08-08

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

TITLE

(X6) DATE

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

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W 102 Continued From page 1
This CONDITION is not met as evidenced by:
The facility's governing body failed to maintain general operating direction over the facility.
[Cross Reference W104]

The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the Conditions of Client Protections [Cross Reference W122]; Facility Staffing [Cross Reference W158] and Health Care Services [Refer to W318].

W 104 483.410(a)(1) GOVERNING BODY

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on staff interviews, and record verification the governing body failed to ensure that the facility consistently exercised general policy, and operating direction over the facility.

The findings include:

1. Cross Reference W186. The governing body failed to develop policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments.
2. Cross Reference W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) ensured that a rolling walker was obtained as recommended by

W 102

W 104 Currently RCM transportation policy requires two staff in the van when they are 2 or more individuals in the vehicle. When there are 2 or more individuals in the van there must be at least one attendant in the rear of the van.
The governing body has amended the transportation policy to maintain one or more attendants to ensure that individuals are monitored to prevent injuries, and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments, or during other activities.
Refer to attachment # 1.a 4-25-08

All staff were trained on the amended transportation policy. 4-29-08
refer to attachment 1.b

Client # 1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08
Refer to attachment #2
In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.

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W 104	Continued From page 2 the Physical Therapist (PT) one of one client in the investigation. 3. Cross Reference W436. The Governing Body failed to ensure that the recommended adaptive equipment had been provided and maintained in accordance to their recommended needs for one of one client in the investigation. 4. Cross Reference W 322. The Governing Body failed to ensure that the facility's medical services provided a through medical examination to ensure that optimal health care and services were provided for one of one client in the investigation. 5. Cross Reference W 331. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of one client in the investigation.	W 104	Client # 1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT. Refer to W 322 (1. a, b, c, d, e, f,) P. 17 Refer to W 322 (2. a, b, c, d, e,f, g, h,) P. 18, 19, 20 Refer to W 331 P. 23	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to develop and implement effective policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments;[Cross Reference W149] and the facility failed to provide a rolling walker in good repair for one of one client being investigated [Cross Reference W436]. The effects of these systemic practices results in	W 122	Refer to W 104 P.2 (1.a) Refer to W 436 P.25 1-09-08	4-22-08

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W 122 Continued From page 3
the failure of the facility to protect its clients from harm and to ensure their general safety and well being.

W 122

W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS

W 149

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on staff interview and record verification, the facility failed to develop and implement its established policies to ensure the health and safety for for one of one client being investigated. (Client #1).

The finding includes:

The facility failed to develop policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments as evidenced below:

1. Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, she was alone with Client #1 when he became verbally abusive and initially refused to get out of the van. The client exited the van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Client #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side."

Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling was submitted on 1-09-08
Refer to attachment #2
In the future, the Qmnp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.

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W 149	<p>Continued From page 4</p> <p>Further interview revealed that DSP1 #1 called the facility on the cell phone for assistance to get Client #1 off the ground.</p> <p>Interview with DSP1 #2 on February 25, 2008 at approximately 6:30 PM revealed that on January 11, 2008, she was in the facility with the rest of the individuals when DSP1 #1 called into the facility and asked her to come outside and help her because Client #1 had fallen. DSP1 #2 assisted DSP1 #1 to pick up Client #1 who was on the ground because Client#1 said that he could not walk. Further interview revealed that DSP1#2 went back into the facility to get a wheelchair for Client #1 and assisted DSP1 #1 in getting Client #1 out of the van into the wheelchair and pushed him into the facility.</p> <p>Interview with the the Qualified Mental Retardation Professional (QMRP) on February 28, 2008 at approximately 10:45 AM revealed that the facility staff usually transported Client #1 and DSP1#1 to the dialysis center and returned to pick them up in the van after the dialysis procedure was completed. Further interview revealed that the QMRP was unaware that DSP1#1 was in the van alone when she transported Client #1 to the dialysis center.</p> <p>Interview with LPN #2 on January 25, 2008 at approximately 6:00PM revealed that on January 11, 2008, direct care staff reported that Client #1 got down from the van and tried walking with his walker and then fell on his buttocks. Further interview revealed that Client #1 was transported to the emergency room after the nurse determined that the client had limited range of motion of his right leg.</p>	W 149	<p>Currently RCM transportation policy requires two staff in the van when they are 2 or more individuals in the vehicle. When there are 2 or more individuals in the van there must be at least one attendant in the rear of the van.</p> <p>The governing body has amended the transportation policy to maintain one or more attendants to ensure that individuals are monitored to prevent injuries, and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments, or during other activities. Refer to attachment # 1.a 4-25-08</p> <p>All staff were trained on the amended transportation policy. refer to attachment 1.b 4-29-08</p> <p>In the future, the provider will ensure that there is a sufficient # of staff in the van when transporting the individuals to ensure their safety.</p> <p>Client #1 was sent to the ER for evaluation following a fall, and not just to have an X-ray of his right hip. In the future, the nursing staff will ensure that the Primary Care Physician specifies the type of diagnostic test to be completed.</p>	
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W 149	Continued From page 5 Review of an Emergency Discharge Summary, dated January 11, 2208, on February 25, 2008 at approximately 4:14 PM revealed that Client #1 was transported to the hospital emergency room for evaluation of a fall. Further review revealed that Client #1 was diagnosed with "right thigh pain, no skin changes consistent with trauma, and a normal bone exam." Review of the policy and procedure entitled "Passenger Assistance In Van" on February 26, 2008 at approximately 12:20 PM revealed "when there are two or more individuals in the vehicle there must be at least one attendant in the rear of the vehicle. There was no evidence that the facility maintained a sufficient number of staff to ensure that the client was monitored to prevent injuries and to address behavior management needs when transporting a medically fragile client safely in/off the van on January 11, 2008. 2. Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 28, 2008, she was alone with Client #1 when he initially refused to get into the van after his dialysis treatment was completed. After taking to Client #1 for approximately ten minutes he agreed to get into the back seat of the van with assistance. DSP1#1 revealed that after driving for approximately ten to fifteen minutes she heard Client #1 making a gurgling sound and observed him shaking all over. Further interview revealed that DSP1#1 pulled the van over to the curb near Mount Olivet Road, NE, and called 911. Review of District of Columbia Fire and Emergency Medical Services Department (EMS)	W 149	Refer to W 104 P.2 Attachment # 1a & b	4-25-08 4-29-08
			Refer to W 104 P.2 Attachment # 1a & b	4-25-08 4-29-08

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W 149	Continued From page 6 Report on March 27, 2008 at approximately 11:30AM revealed that on January 28, 2008, they arrived [time unspecified] at the 1000 block of Mount Olivet Road, NE, Washington D.C. 20018, and observed Client #1 in the rear seat of the van. EMS stated that the caregiver "who was the driver" reported "hearing some noises from the rear and pulled van over and found pt. [Client #1] slumped over." EMS witnessed Client #1 have two seizures [time unspecified] prior to being transported to the hospital. There was no evidence that the facility maintained a sufficient number of staff to ensure that the client was monitored to prevent injuries and to address behavior management needs when transporting a medically fragile client safely in/off the van on January 28, 2008.	W 149	Refer to W 104 P.2 Attachment # 1a & b	4-25-08 4-29-08	
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on staff interviews and record reviewed the facility's Qualified Mental Retardation Professional (QMRP) failed to effectively coordinate services to meet the needs for its clients [Cross Reference W159]; failed to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments [Cross Reference W186] and failed to ensure that each employee demonstrated competency in implementation of the client's Behavior Support Plan (BSP). (Client #1)	W 158	Refer to W 104 P.2 1 a & b All staff were trained on client # 1 BSP on 1-16-08 and the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.	4-25-08 4-29-08	

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W 158	Continued From page 7 [Cross Reference W193].	W 158		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensured the client's safety as a rolling walker was not provided; failed to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments and failed to ensure that staff demonstrated competency in the implementation of the Behavior Support Plan (BSP) for one of one client being investigated. (Client # 1)</p> <p>The findings include:</p> <p>1. The QMRP failed ensure that a rolling walker was obtained for Client # 1 as recommended by the Physical Therapist (PT) as evidenced by:</p> <p>Observation of Client #1's bedroom on February 25, 2008 at approximately 7:00 PM revealed that there was a rolling walker with two bent legs and a standard type walker.</p>	W 159	<p>Refer to W 104 P.2 Attachment # 1a & b</p> <p>Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.</p>	<p>4-25-08 4-29-08</p>

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W 159 Continued From page 8

Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, Client #1 was verbally abusive and initially refused to get out of the van. The client exited the van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Client #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side." He sustained injury to his right upper leg. Further interview with the DSP1 revealed that the walker being used was not a rolling walker.

DSP1 #2 was interviewed on February 25, 2008 at approximately 6:30 PM and explained that Client #1 became very angry one day (unknown date), picked up his rolling walker and began banging the rolling walker on the floor. The two legs on the rolling walker bent during this behavioral episode. The DSP1 reported that the client had previously destroyed another rolling walker. Interview with Licensed Practical Nurse (LPN) #1, on February 26, 2008 at approximately 11:20 AM, revealed that a standard walker was obtained after the client destroyed the second rolling walker so that the client could attend his dialysis treatments.

Review of the Physical Therapy assessment, dated October 9, 2007 on February 25, 2008 at approximately 3:49 PM revealed that Client #1 had decreased bi-lateral hip extension, plantar flexion, hip and ankle weakness and that stand by assistance was to be provided in the community for safety and a rolling walker was recommended for ambulation. Review of Client #1's Behavioral Support Plan (BSP) dated December, 2007, on February 25, 2008 at approximately 1:20 PM

W 159

Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08
Refer to attachment #2
In the future, the Qmnp will ensure that the adaptive equipment is obtained on a timely manner as recommended by the PT.

Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08
Refer to attachment #2
In the future, the Qmnp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.

Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08
Refer to attachment #2
In the future, the Qmnp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.

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W 159	<p>Continued From page 9</p> <p>revealed targeted behaviors that included verbal abuse and property destruction.</p> <p>Interview with LPN #2 on January 25, 2008 at approximately 6:00PM revealed that on January 11, 2008, direct care staff reported that Client #1 got down from the van and tried walking with his walker and then fell on his buttocks. Further interview revealed that Client #1 was transported to the emergency room after the nurse determined that the client had limited range of motion of his right leg.</p> <p>Review of a physician's progress note dated January 11, 2008, on February 25, 2007 at approximately 4:00 PM revealed the facility's nurse notified the Primary Care Physician by telephone to report the client's fall and complaint of hip pain. She also reported that the client was unable to stand or walk. Further review of the PCP notes revealed that Client #1 was sent to the emergency room for an x-ray.</p> <p>An Emergency Discharge Summary dated January 11, 2008, on February 25, 2008 at approximately 4:14 PM revealed that Client #1 was transported to the hospital emergency room for evaluation of a fall. Further review revealed that Client #1 was diagnosed with "right thigh pain, no skin changes consistent with trauma, and a normal bone exam." The recommendations included to prescribe Tylenol and Motrin for pain and to follow-up with the primary care physician (PCP).</p> <p>There was no evidence that the QMRP had ensured the client's safety as a rolling walker was not provided for the client's use while ambulating. Also, the QMRP failed to ensure that the available</p>	W 159	<p>Client # 1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.</p> <p>Client #1 was sent to the ER for evaluation following a fall on 1-11-08 and not just to have an X-ray of his right hip. In the future, the nursing staff will ensure that the Primary Care Physician specifies the the type of diagnostic test to be completed.</p> <p>Client #1 was sent to the ER for evaluation following a fall, and not just to have an X-ray of his right hip. In the future, the nursing staff will ensure that the Primary Care Physician specifies the the type of diagnostic test to be completed.</p> <p>Client # 1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT.</p>	

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W 159	Continued From page 10 rolling walker was in good repair. 2. Cross Reference W186. The QMRP failed to maintain a sufficient number of staff to ensure that Client #1 was monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments;	W 159	Refer to W. 104 P.2 Attachment # 1 a & b All staff were trained on client # 1 BSP on 1-16-08 additionally, the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.	4-25-08 4-29-08
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews, and record verification, the facility failed to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments. The findings include: 1. Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, she was alone with Client #1	W 186	All staff were trained on client # 1 BSP on 1-16-08 and the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.	

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W 186	<p>Continued From page 11</p> <p>when he became verbally abusive and initially refused to get out of the van. The client exited the van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Client #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side." Further interview revealed that DSP1 #1 called the facility on the cell phone for assistance to get Client #1 off the ground.</p> <p>Interview with DSP1 #2 on February 25, 2008 at approximately 6:30 PM revealed that on January 11, 2008, she was in the facility with the rest of the individuals when DSP1 #1 called into the facility and asked her to come outside and help her because Client #1 had fallen. DSP1 #2 assisted DSP1 #1 to pick up Client #1 who was on the ground because Client#1 said that he could not walk. Further interview revealed that DSP1#2 went back into the facility to get a wheelchair for Client #1 and assisted DSP1 #1 in getting Client #1 out of the van into the wheelchair and pushed him into the facility.</p> <p>Interview with the the Qualified Mental Retardation Professional (QMRP) on February 28, 2008 at approximately 10:45 AM revealed that the facility staff usually transported Client #1 and DSP1#1 to the dialysis center and returned to pick them up in the van after the dialysis procedure was completed. Further interview revealed that the QMRP was unaware that DSP1#1 was in the van alone when she transported Client #1 to the dialysis center.</p> <p>Interview with LPN #2 on January 25, 2008 at approximately 6:00PM revealed that on January 11, 2008, direct care staff reported that Client #1</p>	W 186	<p>All staff were trained on client # 1 BSP on 1-16-08 and the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.</p> <p>All staff were trained on client # 1 BSP on 1-16-08 and the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.</p> <p>Currently RCM transportation policy requires two staff in the van when they are 2 or more individuals in the vehicle. When there are 2 or more individuals in the van there must be at least one attendant in the rear of the van. The governing body has amended the transportation policy to maintain a sufficient number of staff to ensure that individuals are monitored to prevent injuries, and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments, or during other activities. Refer to attachment # 1.a 4-25-08 All staff were trained on the amended transportation policy. refer to attachment 1.b 4-29-08 In the future, the provider will ensure that there is a sufficient # of staff in the van when transporting the individuals to ensure their safety.</p>	

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W 186	Continued From page 12 got down from the van and tried walking with his walker and then fell on his buttocks. Further interview revealed that Client #1 was transported to the emergency room after the nurse determined that the client had limited range of motion of his right leg. Review of an Emergency Discharge Summary, dated January 11, 2008, on February 25, 2008 at approximately 4:14 PM revealed that Client #1 was transported to the hospital emergency room for evaluation of a fall. Further review revealed that Client #1 was diagnosed with "right thigh pain, no skin changes consistent with trauma, and a normal bone exam." Review of the policy and procedure entitled "Passenger Assistance In Van" on February 26, 2008 at approximately 12:20 PM revealed "when there are two or more individuals in the vehicle there must be at least one attendant in the rear of the vehicle. There was no evidence that the facility maintained a sufficient number of staff to ensure that the client was monitored to prevent injuries and to address behavior management needs when transporting a medically fragile client safely in/off the van on January 11, 2008. 2. Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 28, 2008, she was alone with Client #1 when he initially refused to get into the van after his dialysis treatment was completed. After taking to Client #1 for approximately ten minutes he agreed to get into the back seat of the van with assistance. DSP1#1 revealed that after driving for approximately ten to fifteen minutes she heard	W 186	Client #1 was sent to the ER for an evaluation following a fall, and not just to have an X-ray of his right hip on 1-11-08. In the future, the nursing staff will ensure that the Primary Care Physician specifies the the type of diagnostic test to be completed. Refer to W 104 P. 2 Attachment #1 a & b Refer to W 104 P. 2 attachment #1 a & b Refer to W 104 P. 2 Attachment #1 a & b	4-25-08 4-29-08 4-25-08 4-29-08 4-25-08 4-29-08	

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W 186	<p>Continued From page 13</p> <p>Client #1 making a gurgling sound and observed him shaking all over. Further interview revealed that DSP1#1 pulled the van over to the curb near Mount Olivet Road, NE, and called 911.</p> <p>Review of District of Columbia Fire and Emergency Medical Services Department (EMS) Report on March 27, 2008 at approximately 11:30AM revealed that on January 28, 2008, they arrived [time unspecified] at the 1000 block of Mount Olivet Road, NE, Washington D.C. 20018, and observed Client #1 in the rear seat of the van. EMS stated that the caregiver "who was the driver" reported "hearing some noises from the rear and pulled van over and found pt. [Client #1] slumped over." EMS witnessed Client #1 have two seizures [time unspecified] prior to being transported to the hospital.</p> <p>There was no evidence that the facility maintained a sufficient number of staff to ensure that the client was monitored to prevent injuries and to address behavior management needs when transporting a medically fragile client safely in/off the van on January 28, 2008.</p>	W 186	<p>Refer to W 104 P. 2 Attachment #1 a & b</p> <p>4-25-08 4-29-08</p> <p>Refer to W 104 P. 2 Attachment #1 a & b</p> <p>4-25-08 4-29-08</p>
W 193	<p>483.430(e)(3) STAFF TRAINING PROGRAM</p> <p>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility staff failed to demonstrate competency in implementation the Behavior Support Plan (BSP) for one of one client being investigated. (Client #1)</p>	W 193	<p>Refer to W 158 P.7 Attachment #3 a & b 1-16-08 & 2-06-08</p>

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W 193	<p>Continued From page 14</p> <p>The finding includes:</p> <p>Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, Client #1 was verbally abusive and initially refused to get out of the van. Further interview revealed that Client #1 exited the van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Client #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side." Interview with the Qualified Mental Radiation Professional (QMRP) on February 28, 2008 at approximately 12:34 PM revealed that the staff was re-trained on Client #1's BSP on January 16, 2008. Review of an Incident Investigation Report dated January 15, 2008, on February 26, 2008 at approximately 1:00 PM revealed that Client #1 sustained injury to his right thigh after a fall on January 11, 2008. Further review revealed a recommendation that the facility staff be re-trained on Client #1's BSP. Review of an emergency room medical consultation dated January 12, 2008 on February 25, 2008 at approximately 2:30 PM revealed that Client #1 was diagnosed with right thigh pain. Review of the Psychological assessment dated October 8, 2007 on February 25, 2008 at approximately 1:20 PM revealed that Client #1 was unable to comprehend the severity of his medical issues and lacked sufficient judgment to weigh the consequences of his non-compliance against the outcomes of preferred activities. Further review revealed that Client #1's initial resistance to medical support was often in the forms of verbal and physical aggression. Review of Client #1's BSP dated December, 2007 on February 25, 2008 at approximately 1:30 PM revealed targeted</p>	W 193	<p>Refer to W 158 P.7 Attachment #3 a & b 1-16-08 & 2-06-08</p>	
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W 193	Continued From page 15 behaviors that included non-compliance with structured activities (medical), property destruction, verbal aggression, physical aggression and extreme dysphoria. There was no evidence that on January 11, 2008, the facility staff demonstrated competency in the implementation of the client's BSP.	W 193	Refer to W 158 P.7 Attachment #3 a & b 1-16-08 & 2-06-08	
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 interviews, and record verification, the facility failed to ensure that the facility's medical services provided a through medical examination to ensure that optimal health care and services were provided to meet the needs of the client [Cross Reference W 322] and the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients' needs [Cross Reference W311].	W 318	Refer to W 322 (1. a, b, c, d, e, f,) P. 17 Refer to W 322 (2. a, b, c, d, e,f, g, h,) P. 18, 19, 20 Refer to W 331 P. 23	
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 interviews, and record verification, the	W 322		

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W 322	<p>Continued From page 16</p> <p>facility's medical services failed to provide a through medical examination to ensure that optimal health care and services were provided to meet the needs one of one client being investigated. (Client #1)</p> <p>The findings include:</p> <p>1. Interview with the Primary Care Physician (PCP) on March 3, 2008 at approximately 12:55 PM revealed the following:</p> <p>a. January 11, 2008, the PCP received a telephone call from the facility's nurse that Client #1 had fallen and was complaining of right hip pain and unable to stand or walk. Client #1 was sent to the emergency room for an x-ray.</p> <p>b. January 12, 2008, the PCP received a telephone call from the facility's nurse that Client #1 went to the emergency room and that he did not have a fracture and had "a negative bone scan." Client #1 was prescribed Motrin 400 mg one, three times a day for three days.</p> <p>c. January 14, 2008, the PCP evaluated Client #1 in the group home as a follow-up to his emergency room visit on January 11, 2008, after sustaining a fall. The PCP stated that she could not complete a through assessment of Client #1's injury to his right leg/hip because the client refused to be examined.</p> <p>d. January 18, 2008, Client #1's right knee was cool to touch and non-erythematous, however the client refused to have his hip examined. A recommendation was made for Client #1 to return home and have the staff exam his right leg and hip for "scars, redness, sore and swollen". Staff</p>	W 322	<p>Client # 1 was sent to the ER for an evaluation following a fall not just to have the X-ray of his right hip on 1-11-08</p> <p>In the future, the future, the nursing staff will ensure that the Primary Care Physician specify the type of diagnostic test that needs to be completed.</p> <p>The facility nurse has notified the Primary Care Physician on the ER report which was normal bone exam, no skin changes consistent with trauma.</p> <p>In the future, the Nurse will verify from the PCP of any telephone report from the ER.</p> <p>It is well documented that client #1 consistently refused to have any medical procedure or intervention on 1-14-08; he refused to have his right leg assessed by his Primary Care Physician.</p> <p>In the future, the medical team will ensure that any client with similar behavior will be send to the ER for evaluation.</p> <p>Refer to W 322 C. P. 17</p>	
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was to call the PCP with the results of their examination; however, she could not remember if she was notified of the results of the staff's examination on January 18, 2008. The PCP prescribed the client Motrin 400 mg, one tablet three times a day for three days.

e. January 28, 2008, the PCP examined Client #1 and his right leg was cold to the touch and was unable to assess for a Doppler pulse. There was no lower leg edema and his right knee was flexed. Client #1 refused to extend his right knee or remove his right shoe. A recommendation was made for Client #1 to go for his dialysis treatment than go to the emergency room for evaluation of his cold, painful right leg. The PCP stated that Client #1 needed his dialysis treatment and would just be sitting in the emergency room waiting to be evaluated for his right leg.

f. The PCP stated that she was not able to ascertain whether or not, Client #1's right leg was x-rayed on January 11, 2008 at Washington Hospital Center's emergency room.

2. Review of the medical, nursing and emergency room records revealed the following:

a) Review of the PCP progress notes, dated January 11, 2008 at approximately 1:50 PM revealed the following:

The PCP received a telephone call from the facility's nurse that Client #1 reportedly fell and was complaining of hip pain. Client #1 was unable to stand or walk on the right leg and was sent to the emergency room for an x-ray.

b. Review of an emergency room medical

W 322

Client # 1 Primary Care Physician determined that it was imperative for him to have his dialysis treatment prior to going to the ER for the doppler study.

In the future, the facility will ensure that the client is sent to the ER, and notify the hospital that the individual needs dialysis.

The ER report did not indicate that an X-ray was done on 2-04-08. The surgeon at the hospital where client #1 was hospitalized informed the facility nursing staff that the ER record has no hip X-ray for client #1 for 1-11-08.

Client #1 was sent to the Emergency Room for an evaluation due to a fall, the fact that he was unable to walk, or stand on his right leg, because of the limited ROM.

In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have.

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W 322 Continued From page 18

consultation dated January 12, 2008, on February 25, 2008 at approximately 2:10PM revealed that Client #1 had " right thigh pain, no skin changes consistent with trauma and normal bone exam. " Client #1 was diagnosed with right thigh pain and recommended to take Tylenol and Motrin for pain. Review of the Department of Emergency Medicine patient discharge instructions revealed that Client #1 was diagnosed with right thigh pain and was to follow-up with his PCP and be re-examined in 5-7 days. Further review revealed that Client #1 was to return to the emergency department if he experienced increased pain, passed out, numbness or weakness on one side or confusion; ibuprofen or use Tylenol was be used for pain relief as necessary.

c. Review of the PCP's progress note dated January 14, 2008, at approximately 2:15 PM revealed that Client #1 was diagnosed with right thigh pain and was prescribed Tylenol 400 mg whenever necessary for three days and that Lantus was increased to 10 units subcutaneously every day.

d. Review of a medical consult dated January 18, 2008, on February 25, 2008, at approximately 2:30 PM revealed that Client #1 complained of right hip pain when standing and that his right knee was swollen, cool to touch and non-erythematous. Further review revealed that Client #1 refused to have hip examined and a recommendation was made that Client #1 " return home and have exam of upper right leg and hip for scars, redness, sore and swollen ". Further review revealed that the facility staff was to call the PCP with the results of the examination and the client was prescribed Motrin 400 mg one three times a day, for three days.

W 322

All attempts were made to assess client #1 right leg, but he refused; therefore, he was sent to the Emergency Room by his primary Care Physician for evaluation. In the future, the nursing staff will ensure that the individual is sent back to the ER for evaluation.

The Primary Care Physician has ordered Motrin for pain. In the future the nursing staff will ensure that the individual is sent to the emergency room for evaluation.

Client #1 was evaluated by the PM nurse, and the primary Care Physician was notified about the findings. In the future, both nurses (medication nurse and the charge nurse) will notify the Primary Care Physician on findings of the assessment.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2008
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019	
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W 322	Continued From page 19 e. Review of a medical consult dated January 28, 2008, at approximately 2:40 PM revealed that Client #1's right leg was cold and that the PCP was unable to assess for a Doppler pulse. Further review revealed that there was no lower leg edema and the right knee was flexed and that Client #1 refused to extend his right knee or remove his right shoe. The PCP recommended that Client #1 go to the emergency room after dialysis for evaluation of his cold, painful right leg. f. Review of an incident report dated January 28, 2008, on February 25, 2008 at approximately 10:00AM revealed that Client #1 exhibited seizure like activity on the van after leaving the dialysis center and was transported by the District of Columbia Fire and Emergency Medical Services Department (EMS) in an ambulance to the Washington Hospital Center emergency room for evaluation and treatment of seizure like activity and unresponsiveness. g. Review of the emergency department records dated January 28, 2008, on March 27, 2008 at approximately 11:30AM revealed that Client#1 arrived by EMS with compliant of seizures times two en route to the hospital. Further review revealed that Client #1 was diagnosed with new onset seizures, ESRD and sub acute right Middle Cerebral Artery (MCA) infarction and subsequently admitted to the hospital. h. Review of the External Examination Report from the Chief Medical Examiner dated February 25, 2008, on April 3, 2008 at approximately 9:00 AM revealed that the cause of death was complications following blunt impact injury (Fracture); surgical repair of right hip and	W 322	Client # 1 Primary Care Physician determined that it was imperative for him to have his dialysis treatment prior to going to the ER for a doppler study. In the future, the facility will ensure that the client is sent to the ER, and notify the hospital medical team that the individual needs dialysis. Client #1 exhibited seizure like activity in the van after leaving the dialys center; EMS was activated, and he was transported to WHC for evaluation and treatment via ambulance. Client #1 was admitted, and treated until 2-23-08 when he expired. Client #1 was transported to WHC for evaluation and treatment due to seizure like activity via EMS. He was diagnosed with new onset seizures, ESRD, and sub acute right middle ear Cerebral Artery (MCA) infarction and was admitted to the hospital until he expired on 2-23-08.	

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W 322 Continued From page 20
contributory conditions: Hypertensive and arteriosclerotic cardiovascular disease and mental retardation.

There was no documented evidence that Client #1 received a through examination of his right leg/hip after a witnessed fall by the facility's medical staff on January 11, 2008, to ascertain the full extent of his injury.

2. Cross Reference to W331. The facility's nursing services failed to establish systems to ensure that nursing services were provided in accordance with Client #1's needs.

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 interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for one of one client being investigated. (Client #1)

The findings include:

1. Cross Reference W322. Interview with Licensed Practical Nurse #1 (LPN) on February 25, 2008 at approximately 6:00 PM revealed that Client #1 could not stand-up alone after falling outside the facility. Client #1 had limited range of motion of the right leg as evidenced by his screaming in pain when touched. Interview revealed that LPN #1 informed the Designated Nurse about Client #1's fall and her assessment

W 322

On 1-11-08, the nurse in the facility at the time of the incident reported that client #1 was in pain, refused to walk, and had limited range of motion to his right leg. It was determined by the medical staff that client #1 should be evaluated at the ER to rule out fracture because he was known for him to be uncooperative with any medical procedure/intervention; furthermore, further manipulation of resident #1 right leg to determine the extent of the injury might have caused more pain and injury to client #1.

W 331 In the future, the RN will endeavor to assess any individual with similar behavior who sustains trauma to determine the extent of the injury.

Refer to W 331 P. 18

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W 331	<p>Continued From page 21</p> <p>findings and was instructed to send Client #1 to the emergency room for evaluation. Client #1 was diagnosed with right thigh pain, no skin changes consistent with trauma, and a normal bone exam. LPN # 1 revealed that she believed that Client #1 received an x-ray of his right leg when he went to emergency room; however, she stated that she had not seen the x-ray results.</p> <p>Further interview revealed that Client #1 was assessed by the PCP on January 18, 2008, complaining of right hip pain and that a recommendation was made to have the client return to the group home and have an examination of his upper right leg and hip. LPN #1 stated that she examined Client 1's upper leg and hip found no scars or swelling but that the client was continuously screaming when his right leg was touched.</p> <p>Interview with the Designated Nurse, on February 26, 2008 at approximately 11:20 AM revealed that he was informed by LPN #1 that Client #1 had fallen and had limited range of motion of the right leg. The Designated Nurse revealed that he notified the PCP and that Client #1 was transported in the van by DSP1 #1 to the emergency room. Further interview revealed that Client #1 was treated in the emergency room and was diagnosed with "right thigh pain, no skin changes consistent with trauma, and normal bone exam." However, he stated that had not seen the x-ray results of Client #1's right leg.</p> <p>Interview with the Director of Nursing (DON), on February 26, 2008 at approximately 11:20 AM revealed that the Designated Nurse informed her that Client #1 had fallen on January 11, 2008, and was evaluated in the emergency room and</p>	W 331	<p>Client #1 was sent to the ER for evaluation, and not just to have an X-ray of his right leg/hip following a fall on 1-11-08. The ER report for client #1 did not indicate that an X-ray of his leg and hip was done.</p> <p>Client #1 was sent to the Emergency Room for an evaluation following a fall with limited range of motion of his right leg, pain, and refusing to stand to stand or walk. In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have.</p>

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W 331

Continued From page 22

diagnosed with "right thigh pain, no skin changes consistent with trauma and normal bone exam" and was ordered Motrin 400 mg one, three times a day for three days by the PCP. Client #1 was still complaining of right leg pain on January 12, 2008, and refused to have his right leg assessed for range of motion. The DON stated that the facility did not have the radiology report from the emergency room and that she had not seen the x-ray results of Client #1's right leg. The DON revealed that she was informed on February 2, 2008 that Client #1 was diagnosed with a right hip fracture in the hospital.

Further interview revealed that she attempted to assess Client #1's right leg and hip but he refused to have the leg examined. However she requested that the LPN #1 try to assess Client #1's right leg and hip when the client returned from the dialysis center on January 18, 2008.

Review of a nursing progress note dated January 11, 2008, on February 25, 2008 at approximately 11:00AM revealed that staff reported that Client #1 returned to the facility after dialysis and when he got down from the van and tried walking with his walker he then fell on his buttocks. DSP1 #1 had to request help to bring Client #1 into the facility in a wheelchair because he could not stand-up alone and needed staff to stand on both sides for support. Further review revealed that passive range of motion was achieved with slight limitation on the right leg as evidenced by Client #1 screaming in pain when touched. Client #1 was transported to Washington Hospital Center emergency department with a referral for evaluation of "post fall."

Review of a nursing progress note dated January

W 331

Client# 1 was sent to the emergency room for evaluation following a fall with limited range of motion on his right leg pain, and refusing to stand or walk. The Er report did not indicate that an X-ray of his right leg/hip was done. In the future the facility nurse will request a copy of all diagnostic tests completed a the ER.

Refer to W 322 P.18 2(a)

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W 331	Continued From page 23 18, 2008, on February 26, 2008 at approximately :00AM revealed that Client #1 was assessed by the PCP complaining of right hip pain. PCP orders included that Client #1 return to the group home and have an examination of his " upper right leg and hip for scars, redness, sore and swollen". Further review revealed that she was assisted by three staff members and examined the Client's upper leg and hip and found no scars, redness, sore or swelling but that the client was continuously screaming when his right leg was touched. Review of the Department of Emergency Medicine patient discharge instructions dated January 12, 2008, on February 25, 2008 at approximately 2:10 PM revealed that Client #1 was diagnosed with right thigh pain. Further review revealed that Client #1 was to return to the emergency department if he experienced increased pain, passed out, numbness or weakness on one side or confusion. Review of Client #1's medical records on February 25-26, 2008, lacked definitive evidence of any x-ray results of his right leg/hip. There was no documented evidence that the facility's medical personnel ascertained whether or not Client# 1's right hip/leg was x-rayed at the hospital to ascertain the extent of his injury or sent the client back to the emergency room for evaluation.	W 331	Client #1 complained of his right knee pain on 1-18-08. He was partially assessed by his Primary Care Physician due to the fact that he refused to fully be assessed. His PCP instructed the nursing staff to assess him for scars, redness, pain or swelling. Upon assessment, the nurse indicated the assessment findings. In the future, the medical team will ensure the individual is sent to the ER for further evaluation. Client #1 was evaluated at the emergency room. In the future client will be sent back to the emergency room whenever he complains of pain after the emergency room visit. The facility nursing staff requested for the result of the 1-11-08 X-ray of resident #1 from the Surgeon on 2-04-08. The Sugeon informed the facility nursing staff that there was no record of an X-ray that was done on 1-11-08. The hospital was not receptive to providing any medical information on resident #1 during his hospitalization from 1-29-08 through 2-23-08, except at his discharge conference on 2-15-08.		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces,	W 436			

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W 436	<p>Continued From page 24 and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a rolling walker in good repair for one of one client being investigated.</p> <p>The finding includes:</p> <p>[Cross Reference W122,W159] Client #1's rolling walker was observed with two bent legs. On February 25, 2008, interview with the direct care staff revealed that the client damaged his rolling walker prior to January 11, 2008. Since that time, he used a standard walker (without wheels) and a wheelchair for mobility. It should be noted that on January 11, 2008, the client fell while attempting to ambulate using the standard walker and injured himself.</p> <p>On February 26, 2008, the nurse stated that the rolling walker was replaced by the standard walker. It should be further noted that the client's physical therapist recommended a rolling walker to ensure his safety while ambulating.</p>	W 436	<p>The Client # has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is obtained on a timely manner as recommended by the PT.</p> <p>Refer to W 149 P. 4 Attachment # 2</p>		

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I 000	INITIAL COMMENTS On February 23, 2008, the Health Regulation Licensing Administration (HRLA) was notified via facsimile by the Incident Management Coordinator at RCM of Washington, Inc. (Intermediate Care Facility for the Mental Retarded) of the death of Resident #1, who resided at a RCM, Inc. facility located at 1318 45th St., NE. The information received via facsimile indicated that Resident #1 had been hospitalized at Washington Hospital Center with a diagnosis of seizure disorder since January 29, 2008 and died on February 23, 2008. Based on the above preliminary findings, a surveyor from the HRLA initiated an onsite investigation on February 25, 2008, to determine compliance with federal and local standards of care prior to Resident #1's death. The results of the investigation were based on observations, interviews with the administrative personnel, and the facility's nursing and direct care staff. Also the findings were based on the review of the client's habilitation and medical, and the facility's administrative records; including incident reports. On February 29, 2008, interviews were conducted at the day program with the nursing staff and administrative staff. On March 3, 2008, an interview was conducted with the Primary Care Physician at her medical clinic.	I 000			
I 163	3507.4(a) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (a) General administration, which covers the governing body, organization charts, internal assessment of the quality of care, and fiscal management;	I 163			

Health Regulation Administration

Angela Brumby
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

Program Director
TITLE

(X6) DATE

4-03-08

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I 163	Continued From page 1 This Statute is not met as evidenced by: Based on an unusual incident report, interviews with staff, and the review of records, the GHMRP's governing body failed to consistently provide operational directions over the facility's internal assessment of the quality of care for one of one resident being investigated. The findings include: 1. Cross Reference W186. The governing body failed to develop policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile residents' safely in/off the van during medical appointments. 2. Cross Reference W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) ensured that a rolling walker was obtained as recommended by the Physical Therapist (PT) one of one resident in the investigation. 3. Cross Reference W186. The Governing Body failed to ensure that the recommended adaptive equipment had been provided and maintained in accordance to their recommended needs for one of one resident in the investigation. 4. Cross Reference BW 322. The Governing Body failed to ensure that the facility's medical services provided a through medical examination to ensure that optimal health care and services were provided for one of one resident in the investigation. 5. Cross Reference BW 331. The governing body	I 163	Currently RCM transportation policy requires two staff in the van when they are 2 or more individuals in the vehicle. When there are 2 or more individuals in the van there must be at least one attendant in the rear of the van. The governing body has amended the transportation policy to maintain a sufficient number of staff to ensure that individuals are monitored to prevent injuries, and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments, or during other activities. Refer to attachment # 1.a All staff were trained on the amended transportation policy. refer to attachment 1.b The Client #1 has destroyed several rolling walkers prior to the incident that occurred on 1-11-08; however, a 719-A form requesting a rolling walker was submitted on 1-09-08 Refer to attachment #2 In the future, the Qmrp will ensure that the adaptive equipment is available, or obtained on a timely manner as recommended by the PT. Refer to W 186 P. 12 Refer to W 322 (1. a, b, c, d, e, f,) P. 17 Refer to W 322 (2. a, b, c, d, e,f, g, h,) P. 18, 19, 20	4-25-08 4-29-08

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I 163	Continued From page 2 failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of one resident in the investigation.	I 163	Client #1 was sent to the Emergency Room for an evaluation following a fall with limited range of motion of his right leg, pain, and refusing to walk.	
I 165	<p>3507.4(c) POLICIES AND PROCEDURES</p> <p>The manual shall incorporate policies and procedures for at least the following:</p> <p>(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident;</p> <p>This Statute is not met as evidenced by: Based on an unusual incident report, interviews with staff, and the review of records, the GHMRP's governing body failed to incorporate policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically fragile residents safely in/off the van during medical appointments.</p> <p>The findings include:</p> <p>1. Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, she was alone with Resident #1 when he became verbally abusive and initially refused to get out of the van. The client exited the van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Resident #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side." Further interview revealed that DSP1 #1 called the facility on the cell phone for assistance to get Resident #1 off the ground.</p>	I 165	<p>In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have.</p> <p>Currently RCM transportation policy requires two staff in the van when they are 2 or more individuals in the vehicle. When there are 2 or more individuals in the van there must be at least one attendant in the rear of the van.</p> <p>The governing body has amended the transportation policy to maintain a sufficient number of staff to ensure that individuals are monitored to prevent injuries, and to address behavior management needs when transporting medically fragile clients safely in/off the van during medical appointments, or during other activities. Refer to attachment # 1.a 4-25-08</p> <p>All staff were trained on the amended transportation policy. 4-29-08 refer to attachment 1.b</p> <p>In the future, the provider will ensure that there is a sufficient # of staff in the van when transporting the individuals to ensure their safety</p>	

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I 165	Continued From page 3 Interview with DSP1 #2 on February 25, 2008 at approximately 6:30 PM revealed that on January 11, 2008, she was in the facility with the rest of the individuals when DSP1 #1 called into the facility and asked her to come outside and help her because Resident #1 had fallen. DSP1 #2 assisted DSP1 #1 to pick up Resident #1 who was on the ground because Resident #1 said that he could not walk. Further interview revealed that DSP1#2 went back into the facility to get a wheelchair Resident #1 and assisted DSP1 #1 in getting Resident #1 out of the van into the wheelchair and pushed him into the facility. Interview with the the Qualified Mental Retardation Professional (QMRP) on February 28, 2008 at approximately 10:45 AM revealed that the facility staff usually transported Resident #1 and DSP1#1 to the dialysis center and returned to pick them up in the van after the dialysis procedure was completed. Further interview revealed that the QMRP was unaware that DSP1#1 was in the van alone when she transported Resident #1 to the dialysis center. Interview with LPN #2 on January 25, 2008 at approximately 6:00PM revealed that on January 11, 2008, direct care staff reported that Client #1 got down from the van and tried walking with his walker and then fell on his buttocks. Further interview revealed that Resident #1 was transported to the emergency room after the nurse determined that the resident had limited range of motion of his right leg. Review of an Emergency Discharge Summary January 11, 2208, on February 25, 2008 at approximately 4:14 PM revealed that Resident #1 was transported to the hospital emergency	I 165	Refer to W 104 P.2 Attachment #1. a & b Refer to W 104 P.2 Attachment #1. a & b Client #1 was sent to the Emergency Room for an evaluation following a fall with limited range of motion of his right leg, pain, and refusing to walk. In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have. Client #1 was evaluated , and assessed in the emergency room for a fall. In the future client will be sent back tot the emergency room whenever he complains of pain after the emergency room visit.	4-25-09 4-29-08 4-25-09 4-29-08

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I 165	Continued From page 5 and observed Resident #1 in the rear seat of the van. EMS stated that the caregiver "who was the driver" reported " hearing some noises from the rear and pulled van over and found pt. [Resident #1] slumped over." EMS witnessed Resident #1 have two seizures [time unspecified] prior to being transported to the hospital. There was no evidence that the facility maintained a sufficient number of staff to ensure that the client was monitored to prevent injuries and to address behavior management needs when transporting a medically fragile resident safely in/off the van on January 28, 2008.	I 165	Refer to W 104 P.2 Attachment #1. a & b	4-25-09 4-29-08
I 229	3510.5(f) STAFF TRAINING 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 interviews and record verification, the facility staff failed to demonstrate competency in the implementation of the Behavior Support Plan (BSP) for one of one resident being investigated. (Resident #1) The finding includes: Interview with DSP1 #1 on February 25, 2008 at approximately 1:32 PM revealed that on January 11, 2008, Resident #1 was verbally abusive and initially refused to get out of the van. Further interview revealed that Resident #1 exited the	I 229		

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I 229	Continued From page 6 van, ten minutes later, with assistance. He stood beside the van holding his walker. When attempts were made to assist Resident #1 to ambulate with the walker, he refused and fell down on the ground "in a sitting position on his right side." Interview with the Qualified Mental Radiation Professional (QMRP) on February 28, 2008 at approximately 12:34 PM revealed that the staff was re-trained on Resident #1's BSP on January 16, 2008. Review of an Incident Investigation Report dated January 15, 2008, on February 26, 2008 at approximately 1:00 PM revealed that Resident #1 sustained injury to his right thigh after a fall on January 11, 2008. Further review revealed a recommendation that the facility staff be re-trained on Resident #1's BSP. Review of an emergency room medical consultation dated January 12, 2008 on February 25, 2008 at approximately 2:30 PM revealed that Resident #1 was diagnosed with right thigh pain. Review of the Psychological assessment dated October 8, 2007 on February 25, 2008 at approximately 1:20 PM revealed that Resident #1 was unable to comprehend the severity of his medical issues and lacked sufficient judgment to weigh the consequences of his non-compliance against the outcomes of preferred activities. Further review revealed that Resident #1's initial resistance to medical support was often in the forms of verbal and physical aggression. Review of Resident #1's BSP dated December, 2007 on February 25, 2008 at approximately 1:30 PM revealed targeted behaviors that included non-compliance with structured activities (medical), property destruction, verbal aggression, physical aggression and extreme dysphoria. There was no evidence that on January 11, 2008, the facility staff demonstrated competency in the	I 229	All staff were trained on client # 1 BSP on 1-16-08 and the staff who drove client # 1 was retrained again on 2-06-08 Refer to attachment #3 a & b In the future the management will ensure that the staff are trained on the client BSPs on an ongoing basis.	

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I 229	Continued From page 7 implementation of the client's BSP.	I 229		
I 391	<p>3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:</p> <p>(a) Medicine;</p> <p>This Statute is not met as evidenced by: Based on interviews, and record verification, the facility's medical services failed to carry out and monitor necessary professional interventions and provide a through medical examination to meet the needs one of one resident being investigated. (Resident #1)</p> <p>The findings include:</p> <p>Interview with the Primary Care Physician (PCP) on March 3, 2008 at approximately 12:55 PM revealed the following:</p> <p>a. January 11, 2008, the PCP received a telephone call from the facility's nurse that Resident #1 had fallen and was complaining of right hip pain and unable to stand or walk. Resident #1 was sent to the emergency room for an x-ray.</p>	I 391	<p>Client #1 was sent to the Emergency Room for an evaluation following a fall with limited range of motion of his right leg, pain, and refusing to walk.</p> <p>In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have</p>	

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I 391	Continued From page 8 b. January 12, 2008, the PCP received a telephone call from the facility's nurse that Resident #1 went to the emergency room and that he did not have a fracture and had a negative bone scan. Resident #1 was prescribed Motrin 400 mg one, three times a day for three days. c. January 14, 2008, the PCP evaluated Resident #1 in the group home as a follow-up to his emergency room visit on January 11, 2008, after sustaining a fall. The PCP stated that she could not thoroughly examine Resident #1's injury to his right leg/hip because the client refused to be examined. d. January 18, 2008, Resident #1's right knee was cool to touch and non-erythematous, however the client refused to have his hip examined. A recommendation was made for Resident #1 return home have the staff exam his right leg and hip "scars, redness, sore and swollen". Staff was to call the PCP with the results of the examination ; however she stated that she could not remember if she was notified of the results of the examination of Resident #1's right leg. on January 18, 2008. Resident #1 was prescribed Motrin 400 mg one tablet three times a day, times three days. e. January 28, 2008, the PCP examined Resident #1 and his right leg was cold to the touch and was unable to assess for a Doppler pulse. There was no lower leg edema and his right knee was flexed. Resident #1 refused to extend his right knee or remove his right shoe. A recommendation was made for Resident #1 to go for his dialysis treatment than go to the emergency room for evaluation of his cold, painful right leg. The PCP stated that Resident #1 needed his dialysis treatment and would just be	I 391	The facility nurse has notified the Primary Care Physician on the ER report which was normal bone exam, no skin changes consistent with trauma. In the future, the Nurse will verify from the PCP of any telephone report from the ER. It is well documented that client #1 consistently refused to have any medical procedure or intervention on 1-14-08; he refused to have his right leg assessed by his Primary Care Physician. In the future, the medical team will ensure that any client with similar behavior be sent to the primary Care Physician clinic when assessment in the home is unsuccessful. Refer to W 322 C. P. 17 Client # 1 Primary Care Physician determined that it was imperative for him to have his dialysis treatment prior to going to the ER for thr doppler study. In the future, the facility will ensure that the client is sent to the ER, and notify the hospital that the individual needs dialysis.		

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I 391	Continued From page 9 sitting in the emergency room waiting to be evaluated for his right leg. f. The PCP stated that she was never able to ascertain whether or not, Resident #1's right leg was x-rayed on January 11, 2008 at the emergency room. Review of the PCP progress note dated January 11, 2008 at approximately 1:50 PM revealed that she received a telephone call from the facility's nurse that Resident #1 reportedly fell and was complaining of hip pain. Resident #1 was unable to stand or walk on the right leg and was sent to the emergency room for an x-ray. Review of an emergency room medical consultation dated January 12, 2008, on February 25, 2008 at approximately 2:10PM revealed that Resident #1 had " right thigh pain, no skin changes consistent with trauma and normal bone exam. " Resident #1 was diagnosed with right thigh pain and recommended to take Tylenol and Motrin for pain. Review of the Department of Emergency Medicine patient discharge instructions revealed that Resident #1 was diagnosed with right thigh pain and was to follow-up with his PCP and be re-examined in 5-7 days. Further review revealed that Resident #1 was to return to the emergency department if he experienced increased pain, passed out, numbness or weakness on one side or confusion; ibuprofen or use Tylenol was be used for pain relief as necessary. Review of the PCP's progress note dated January 14, 2008, at approximately 2:15 PM revealed that Resident #1 was diagnosed with right thigh pain and was prescribed Tylenol 400 mg whenever necessary times three days and	I 391	The ER report did not indicate that an X-ray was done on 2-04-08. The surgeon at the hospital where client #1 was hospitalized informed the facility nursing staff that the ER record has no right hip/leg X-ray for client #1 on 1-11-08. Client #1 was sent to the Emergency Room for an evaluation following a fall with limited range of motion of his right leg, pain, and refusing to walk. In the future, the facility nursing staff will ensure that the physician specifies the treatment/intervention that the individual should have. All attempts were made to assess client #1 right leg, but he refused; therefore, he was sent to the Emergency Room by his primary Care Physician for evaluation. In the future, the nursing staff will ensure that the individual is sent back to the ER for evaluation. The Primary Care Physician has ordered Motrin for pain. In the future the nursing staff will ensure that the individual is sent to the emergency room for evaluation.		

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I 391	Continued From page 10 that Lantus was increased to 10 units subcutaneously every day. Review of a medical consult dated January 18, 2008, on February 25, 2008, at approximately 2:30 PM revealed that Resident #1 complained of right hip pain when standing and that his right knee was swollen, cool to touch and non-erythematous. Further review revealed that Resident #1 refused to have hip examined and a recommendation was made that Resident #1 " return home and have exam of upper right leg and hip for scars, redness, sore and swollen ". Further review revealed that the facility staff was to call the PCP with the results of the examination and the resident was prescribed Motrin 400 mg one three times a day, times three days. Review of a medical consult dated January 28, 2008, at approximately 2:40 PM revealed that Resident #1's right leg was cold and that the PCP was unable to assess for a Doppler pulse. Further review revealed that there was no lower leg edema and the right knee was flexed and that Resident #1 refused to extend his right knee or remove his right shoe. The PCP recommended that Resident #1 go to the emergency room after dialysis for evaluation of his cold, painful right leg. Review of an incident report dated January 28, 2008, on February 25, 2008 at approximately 10:00AM revealed that Resident #1 exhibited seizure like activity on the van after leaving the dialysis center and was transported by the District of Columbia Fire and Emergency Medical Services Department (EMS) in an ambulance to the Washington Hospital Center emergency room for evaluation and treatment of seizure like activity and unresponsiveness.	I 391	Client #1 was evaluated by the PM nurse, and the primary Care Physician was notified about the findings. In the future, both nurses (medication nurse and the charge nurse will notify the Primary Care Physician on findings of the assessment. Client # 1 Primary Care Physician determined that it was imperative for him to have his dialysis treatment prior to going to the ER for the doppler study. In the future, the facility will ensure that the client is sent to the ER, and notify the hospital that the individual needs dialysis.	

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I 391	Continued From page 11 Review of the emergency department records dated January 28, 2008, on March 27, 2008 at approximately 11:30AM revealed that Resident #1 arrived by EMS with compliant of seizures times two en route to the hospital. Further review revealed that Resident #1 was diagnosed with new onset seizures, ESRD and sub acute right Middle Cerebral Artery (MCA) infarction and subsequently admitted to the hospital. Review of the External Examination Report for from the Chief Medical Examiner dated February 25, 2008, on April 3, 2008 at approximately 9:00 AM revealed that the cause of death for Resident #1 was complications following blunt impact injury (Fracture); surgical repair of right hip and contributory conditions: Hypertensive and arteriosclerotic cardiovascular disease and mental retardation. There was no documented evidence that Resident #1 received a through examination of his right leg/hip after a witnessed fall by the facility's medical staff on January 11, 2008, to ascertain the full extent of his injury. 2. Cross Reference to W331. The facility's nursing services failed to establish systems to ensure that nursing services were provided in accordance with Resident #1's needs.	I 391	Client #1 was transported to WHC for evaluation and treatment due to seizure like activity via EMS. He was diagnosed with new onset seizures, ESRD, and sub acute right middle ear Cerebral Artery (MCA) infarction and was admitted to the hospital until he expired on 2-23-08. On 1-11-08, the nurse in the facility at the time of the incident reported that client #1 was in pain, refused to walk, and had limited range of motion to his right leg. It was determined by the medical staff that client #1 should be evaluated at the ER to rule out fracture because he was known for him to be uncooperative with any medical procedure/ intervention; furthermore, further manipulation of resident #1 right leg to determine the extent of the injury might have caused more pain and injury to client #1. In the future, the RN will endeavor to assess any individual with similar behavior who sustains trauma to determine the extent of the injury.	
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The	I 395		

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I 395	<p>Continued From page 12</p> <p>professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:</p> <p>(e) Nursing;</p> <p>This Statute is not met as evidenced by: Based on interviews, and record verification, the facility's medical services failed to carry out and monitor necessary professional interventions and provide a through medical examination to meet the needs one of one resident being investigated. (Resident #1)</p> <p>The finding includes:</p> <p>1. Cross Reference W322. Interview with Licensed Practical Nurse #1 (LPN) on February 25, 2008 at approximately 6:00 PM revealed that Resident #1 could not stand-up alone after falling outside the facility. Resident #1 had limited range of motion of the right leg as evidenced by his screaming in pain when touched. Interview revealed that LPN #1 informed the Designated Nurse about Resident #1's fall and her assessment findings and was instructed to send Resident #1 to the emergency room for evaluation. Resident #1 was diagnosed with right thigh pain, no skin changes consistent with trauma, and a normal bone exam. LPN# 1 revealed that she believed that Resident #1 received an x-ray of his right leg when he went to emergency room. However she stated that she had not seen the x-ray results.</p> <p>Further interview revealed that Resident #1 was assessed by the PCP on January 18, 2008, complaining of right hip pain and that a</p>	I 395	<p>There was no indication in the ER report that an X-ray of client # 1's right hip/leg was done on 1-11-08. Resident #1 was diagnosed with right thigh pain, no skin changes consistent with trauma, and normal bone exam. The facility nursing staff would have follow up with the hospital if the ER report indicated that an X-ray was done, and the results was not stipulated.</p> <p>In the future, the nursing staff will enquire from the hospital the type of diagnostic test performed in the ER, if not mentioned in the ER report.</p>	

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I 395	Continued From page 15 Review of the Department of Emergency Medicine patient discharge instructions dated January 12, 2008, on February 25, 2008 at approximately 2:10 PM revealed that Resident #1 was diagnosed with right thigh pain. Further review revealed that Resident#1 was to return to the emergency department if he experienced increased pain, passed out, numbness or weakness on one side or confusion. Review of Resident #1's medical records on February 25-26, 2008, lacked definitive evidence of any x-ray results of his right leg/hip. There is no documented evidence that the facility's medical personnel ascertained whether or not Resident # 1's right hip/leg was x-rayed at the hospital to ascertain the extent of his injury or sent the resident back to the emergency room for evaluation.	I 395	Resident #1 was evaluated by his Primary Care Physician when he complained of right knee pain on 1-11-08. An order was given to treat his right knee pain with Motrin. In the future, the nursing staff will suggest to the PCP to consider an order for ER evaluation with specific diagnostic test. The facility nursing staff requested for the result of the 1-11-08 X-ray result of resident #1. On 2-04-08, the surgeon at WHC informed the facility nursing that there was no record of an X-ray that was done on 1-11-08. The hospital was not receptive to providing medical information on client #1 during his hospitalization from 1-29-08 through 2-23-08, except on 2-15-08 during his case conference.	
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 Qualified Mental Retardation Professional (QMRP) failed to ensured the client's safety as a rolling walker was not provided for one of one client in the investigation. (Client # 1). The finding includes: The QMRP failed ensure that a rolling walker was obtained for Client # 1 as recommended by the	I 422		

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I 500	Continued From page 19 walker. It should be further noted that the client's physical therapist recommended a rolling walker to ensure his safety while ambulating. 2. Section 483.410. The governing body failed to maintain general operational direction over the facility to prevent client injuries. [See W104] 3. Section 483.420. The facility failed to establish an effective policy and procedure to maintain a sufficient number of staff that ensure clients were monitored to prevent injuries. [W149 and W436] 4. Section 483.430. The facility failed to provide adequate staffing to ensure client safety. [See W159, W186 and 193] 5. Section 483.460. The facility failed to ensure adequate preventative care and medical service. [See W322 and W331]	I 500	Refer to W 149 P. 4 Attachment #2 Refer to W 104 P.2 Attachment #1 a & b Refer to W 149 P. 4 Attachment #2 Refer to W 436 P.25 Refer to W 159 P. 10 & 11 W 186 P. 12, 13, 14 W 193 P.14 & 15 Refer to W 322 P. 16, 17, 18, 19, 20, 21. W 331 P. 21, 22, 23, 24.	4-25-08 4-29-08