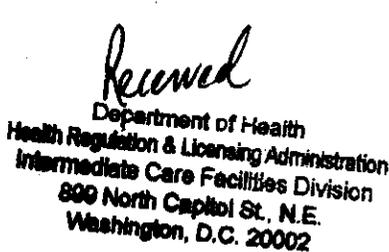


Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/28/2011
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NAME OF PROVIDER OR SUPPLIER TWINS PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4917 FOOTE STREET NE WASHINGTON, DC 20018
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(R 000)	Initial Comments A follow-up inspection was conducted on January 21, 2011, to observe the facility's system of supervision of its residents while in bed. The facility has a residential population of six (6) residents. The findings of the inspection were based on observation, record reviews and interview.	(R 000)		
R 293	<p>Sec. 504.2 Accommodation Of Needs.</p> <p>(2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being; Based on observation and interview, it was determine the facility failed to ensure that two (2) of two (2) patients had access to appropriate health services. (Patient #1 and #2)</p> <p>The findings include:</p> <p>1. On January 21, 2011, an observation of resident #1's room at approximately 9:00 a.m. revealed a sign posted on the door that documented the following " Morphine 5mg/.25ml</p>	R 293	<p>All consumers presently receive house call treatment. All social services are being performed upon recommendation of a physician as needed. Physicians visit monthly or as needed. Will closely monitor monthly.</p> <p>Morphine medication Effective today our RN has informed all staff that only her staff, Washington Home & Community Hospices will ever perform these</p>	1-21-11

Health Regulation Administration

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

TITLE

(X5) DATE

STATE FORM

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R 293 Continued From page 1

(first line on dropper) before his bath and when he is in pain as needed every four (4) hours".

During a second observation on January 21, 2011 at approximately 9:30 a.m., employee #1, who is a certified nursing assistant (CNA), demonstrated for the surveyors how she administers Morphine to resident #1. (It should be noted that employee #1 did not administer Morphine at the time of this inspection. She only demonstrated the procedure).

During a face to face interview with employee #1 on January 21, 2011 at approximately 9:30 a.m., the employee admitted to administering Morphine to resident #1 during bathing and repositioning.

2. During a face to face interview with employee #2 on January 21, 2011 at approximately 8:45 a.m., it was revealed that resident #2 had a new Percutaneous Endoscopic Gastrostomy (PEG) Tube. The employee indicated that resident #2 only had the peg tube for three days.

During an observation on January 21, 2011 at approximately 9:15 a.m. employee #1 demonstrated how she administered Jevity one (1) can bolus feeding via large (piston) syringe to resident #1. It should be noted employee #1 did not administer the feeding during this inspection; She only demonstrated the procedure. During the demonstration, employee #1 did not (1) indicate that she elevates the head of the bed (HOB) prior to administering tube feeding; (2) did not know how to check for residuals; and (3) did not let the feeding flow by gravity (she poured the feeding in the (piston) syringe and then manually pushed the plunger to administer the tube

R 293

duties, her signature is on record daily or whenever these services are performed. Facility nurse will oversee on a monthly bases. 1-24-11

G Tube Feeding Effective 1-22-11 an LRN/RN was retained to administer bolus feeding on a daily bases as long as consumer is located at Twins ALR. In the future if a consumer requires bolus feeding the facility will notify the POA or family in advance for relocation to a place of their choice. Consumer's physician will make this decision. RN will monitor on a monthly bases. 1-22-11

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R 293	Continued From page 2 feeding. During a face to face interview with employee #1 on January 21, 2011 at approximately 9:15 a.m., the employee admitted that a nurse instructed her how to provide bolus feeding to resident #1.	R 293		
R 373	Sec. 506a2 Privacy and Confidentiality. (2) To have their records kept confidential and released only in accordance with their informed uncoerced consent in accordance with District and federal law; Based on observation and interview, it was determined the facility failed to keep one (1) of six (6) resident's records confidential. (Resident #1) The finding includes: On January 21, 2011, an observation at approximately 9:00 a.m. of resident's room revealed a sign posted on the door, that read "Morphine 5mg/.25ml (first line on dropper) before his bath and when he is in pain as needed every four (4) hours". Further observation revealed four sets of initials indicating the facility's staff had administered Morphine a total of four times. During a face to face interview with employee #1 on January 21, 2011 at approximately 9:30 a.m., the finding was acknowledged.	R 373	ALR RN will monitor on a monthly bases to ensure all records are kept confidential. Only hospice RN nurses will administer morphine. No ALR staff will monitor. ALR RN will monitor records on a monthly bases.	1-22-11 1-24-11
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed.	R 481	ISP for Hospice Services has completed an updated ISP with consumers physician. Hospice Aide Care plan is posted for all to follow. RN monitors daily.	1-24-11

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R 481	<p>Continued From page 3</p> <p>Based on record review , it was determined the facility failed to document on the ISP for one (1) of two (2) resident's when and how often services will be provided.</p> <p>The findings include:</p> <p>On January 28, 2011, a review of resident #2's current ISP dated January 23, 2011 and interview with the Administrator indicated that resident #2 was receiving skilled nursing services from a Home Care Agency.</p> <p>Further review of the aforementioned ISP revealed there was no documented evidence of when and how often skilled nursing services were to be provided.</p>	R 481	<p>Visiting Nurse from Professional Health Care Resources has completed their schedule of 1-29-11 her treatment.</p>	
{R 483}	<p>Sec. 604d Individualized Service Plans</p> <p>(d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR.</p> <p>Based on observation, record review and interview, it was determined that the facility failed to update the Individualized Service Plan (ISP) for one (1) of two (2) resident's in the sample. (Resident #2)</p> <p>The findings include:</p> <p>Interview with the direct care staff and</p>	{R 483}	<p>ISP update has been completed by RN & physician and is on file. ISP update will be 1-30-11 monitored on a monthly bases to insure none will be overlooked. _____</p>	

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{R 483}	<p>Continued From page 4</p> <p>observation of resident #2 on January 22, 2011 at approximately 9:30 a.m., revealed the resident had a gastrostomy tube.</p> <p>During a face to face interview with employee #2 on January 22, 2011, at approximately 9:35 a.m., it was revealed that resident #2 returned from hospital with a gastrostomy tube three days prior to this inspection.</p> <p>During a interview with employee #1 on January 22, 2011, at approximately 10:00 a.m., it was revealed that resident #2 was able to eat by mouth and it was further revealed that the resident received bolus feeding of Jevity (one (1) can three times a day) provided by employee #2 and a skilled nurse that visits with the patient daily.</p> <p>On January 28, 2010, at approximately 2:00 p.m. resident #2's record revealed a document entitled, "Discharge Summary-Preliminary Report" dated January 16, 2011. The report indicated resident #2 "...presented with decreased appetite and weight loss. A Percutaneous Endoscopic Tube (peg tube) was placed on January 11, 2011 without incident..." The report also indicated resident #2 was weak and had extreme difficulty walking, although prior to admission she supposedly was able to walk with the assistance of a walker. Skilled nursing for both strengthen and initial peg tube management was recommended, but the grandson preferred she return to existing Assistant Living Residence and have physical therapy done there."</p> <p>Further record review revealed on a current ISP dated November 25, 2010 that failed to include documentation of a service plan to address the</p>	{R 483}	<p>G Tube feeding is being performed by LRN/RN on a monthly bases. Consumer continues to eat and drink well. LRN/RN continue to perform G Tube feedings.</p> <p>G Tube feed is being performed by an RN on a daily bases. Physician also noted consumer is to eat by mouth as much as possible. A chart is in use as to how much food & liquid intake is being given. Her daily bowel & urine are charted and weight charted weekly. Consumer continues to gain weight. Physical therapy revealed consumer is able to walk with a walker when her dementia is in line. Physical therapy will continue as long as needed. RN continues to monitor.</p> <p>Service plan has been revised to include dietary changes. Also to include</p>	
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{R 483}	Continued From page 5 resident's dietary concerns, Peg tube bolus feedings, and physical therapy services. [Also see R393] During a telephone interview with the Assistant Living Administrator (ALA) on January 28, 2011 at approximately 12:00 p.m., it was revealed that resident #2 receives physical therapy services twice a week from a physical therapist who is employed through a Home Care Agency. <u>Based on record reviews and interview, the facility failed to review Individualized Services Plan (ISP) at least every six (6) months for one (1) of four (4) resident's in the sample. (Resident #2)</u> The findings include: On December 20, 2010, at approximately 11:15 a.m., a record review of the resident #2's record revealed an ISP dated February 15, 2010. Further review of record revealed there was no documented evidence the ISP had been reviewed in six months which would have been in August 2010. During a face to face interview the Assistant Living Administrator on December 20, 2010 at approximately 11:45 a.m., the finding was acknowledged.	{R 483}	peg tube bolus feeding is no longer able to be given in ALR. If bolus feeding becomes necessary consumer will be discharged with physician's orders. Physical therapy will be offered with physician's orders. These services will be noted during consumer's physicians visits as often as needed. ISP consumer #2 ISP has been completed by physician and is on file. Kaiser physician has been notified they must sign every six months or as needed. Will monitor every month to ensure no ISP is overlooked.	
R 513	Sec. 606 3 Resident Records (3) A physician's statement, including medical orders and rehabilitation plans; Based on observation, record review and interview, it was determined the facility failed to	R 513	ISP for consumer has been updated with consumer changes. Physician & RN will monitor on a weekly bases to ensure changes are updated as needed.	

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R 513	Continued From page 6 ensure a medication order was in the record for one (1) of one (1) resident's. (Resident #1) The findings include: On January 21, 2011, an observation of patient #1's room at approximately 9:00 a.m. revealed a sign posted on the door that documented the following "Morphine 5 mg/.25 ml (first line on dropper) before his bath and when he is in pain as needed every four (4) hours". On January 21, 2011, a record review of resident's #1's Medication Administration Record (MAR) revealed there was no documented evidence of a physician order for Morphine. Further review of the record revealed there was no documented evidence of a MAR for January 2010 for resident #1 in the record. During a telephone conference with the Director, Program Manager and surveyor on January 21, 2011 at approximately 2:00 p.m., the Director indicated the Morphine was from the hospice nurse. The Director also indicated that she informed the hospice nurse, prior to this inspection, that her ALR staff will not be responsible for administering Morphine to resident #1.	R 513	Morphine (Kadian 10mg by mouth every 24 hours) given by hospice RN only. Hospice RN will monitor MAR everyday medication is given.	1-24-11
R 831	Sec. 905a Medication Administration. (a) Licensed nurses, physicians, physician assistants, and TMEs may administer medications to residents or assist residents with taking their medications. Based on interview and observation, it was determined the facility failed to ensure only licensed nurses, physicians, physician's assistants and TMEs administered medications	R 831	No TME or facility staff will ever administer morphine. Only hospice nurse will administer. Will be monitored by facility nurse monthly.	

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R 831	<p>Continued From page 7</p> <p>for one (1) of two (2) resident's in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On January 21, 2011, an observation of patient #1's room at approximately 9:00 a.m. revealed a sign posted on the door that documented the following: "Morphine 5mg/.25ml (first line on dropper) before his bath and when he is in pain as needed every four (4) hours".</p> <p>During a second observation on January 21, 2011 at approximately 9:30 a.m., employee #1, who is a certified nursing assistant (CNA), demonstrated for the surveyors how she administers Morphine to resident #1. (It should be noted that employee #1 (CNA) did not administer Morphine at the time of this inspection. She only demonstrated the procedure)</p> <p>During a face to face interview with employee #1 (CNA) on January 21, 2011 at approximately 9:30 a.m., the employee admitted to administering Morphine to resident #1 during bathing and repositioning. The employee also acknowledged that she was not a Trained Medication Employee (TME). She stated "they are going to send me to class for that".</p>	R 831	<p>Morphine</p> <p>Only hospice nurse will administer morphine. Nurse will sign each time of her treatment. All staff has been informed of this procedure. Facility nurse will monitor on a monthly bases to ensure this will never reoccur.</p>		