

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD 12-007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1449 ROXANNA ROAD NW WASHINGTON, DC 20012
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1 000	<p>INITIAL COMMENTS</p> <p>An initial licensure survey was conducted from January 15 to January 16, 2008 at this facility prior to the conversion to Medicaid Waiver. At the time of the survey three of the four residents residing in the facility had been hospitalized within four days.</p> <p>Resident #1 was admitted to the hospital on January 10, 2008, because of a significant decrease in his Red Blood Count (RBC). The survey revealed that the Resident, who was admitted to the facility on July 25, 2007, had not received all needed medical services and adaptive equipment as prescribed. According to the facility staff, Resident#1's Medicaid card was not obtained until the third week of December 2007.</p> <p>Resident #2 was admitted to the hospital on January 9, 2008 for wound care treatment. The survey revealed that the facility nurse failed to ensure that the resident's wound care protocol was consistently implemented. The Resident's Individual Support Plan (ISP) was not available during the survey because the Office of the Inspector General (OIG) removed the ISP records from the facility on November 30, 2007.</p> <p>Resident #3 was admitted to the hospital on January 14, 2008 to have the gastric tube replaced; the resident pulled out his gastric tube. It also should be noted the facility nursing staff failed to ensure that the resident had medical appointment follow-ups.</p> <p>The findings of the survey were based on observations in the group home, interviews with direct care, nursing and administrative staff in the home, as well as a review of all available resident</p>	1 000	<p style="text-align: center;">2008 FEB 19 P 2:14</p> <p style="text-align: center;">RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION</p>	

Health Regulation Administration

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

TITLE *Marta Howard* (X6) DATE *2/15/08*
Vice President

6899

SJ5Y11

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I 000	Continued From page 1 and administrative records, including incident reports.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure that the modified diet for one out of four residents in the sample had been reviewed at least quarterly by the consulting dietitian. (Resident #1) The finding includes: Review of Resident #1's nutritional assessment dated August 20, 2007 on January 15, 2008 at approximately 4:15 PM revealed that the resident was recommended a carbohydrate controlled, low sodium, moderate protein, mechanical soft diet. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #1's diet on a quarterly basis.	I 043	I 043 The dietician has reviewed Resident #1's diet (please see attached). A review schedule has been developed which will help in tracking when reports are due. The Qualified Mental Retardation Professional (QMRP) and the RN will quarterly review the records to ensure compliance.	02/10/08 11/25/07
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to	I 180		

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I 180	<p>Continued From page 2</p> <p>efficiently meet the needs for two of four residents in the sample as required by their habilitation plans. (Resident # 1 and Resident # 4)</p> <p>The findings include:</p> <p>1. Review of Resident #1's, physician's orders (POS) dated December 20, 2007 on January 15, 2008 at approximately 11:05AM revealed that the resident has a diagnosis of Diabetes Mellitus. Review of Resident #1's, endocrinology consult dated October 15, 2007 on January 15, 2008 at approximately 11:10AM revealed that the resident had an appointment on that date to be assessed by the endocrinologist. In an interview with the Qualified Mental Retardation Professional (QMRP) on January 15, 2008 at approximately 11:30 AM it was acknowledged that Resident #1 had not received endocrinology services because the facility did not have his Medicaid card when the resident was admitted on July 25, 2007. Further interview revealed that the facility was only able to obtain Resident#1's Medicaid card during the third week of December, 2007. The endocrinology appointment was re-scheduled for January 28, 2008. It should be noted that Resident #1 was admitted to the hospital on January 10, 2007 for a decrease in his Red Blood Count (RBC). There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the endocrinology needs of the resident as required by his habilitation plan.</p> <p>2. Review of Resident #1's, physician's orders (POS) dated December 20, 2007 on January 15, 2008 at approximately 2:30 PM revealed that the resident has diagnoses of left heel wound, right heel ulcer and bi-lateral gangrene of the feet.</p>	I 180	<div style="border: 1px solid black; padding: 5px;"> <p>I 180, 1 In the future, the Administration will consult with the Department on Disability Services (DDS) on pursuing aggressive means of securing Medicaid/Medicare Cards for the residents. Alternatively, a case conference will be held to discuss issues such as missed medical appointments resulting from lack of Medicaid/Medicare Cards. Alternatively, the Administration will explore other means of ensuring that medical appointments are done as scheduled.</p> </div>	02/15/08

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I 180	<p>Continued From page 3</p> <p>Review of Resident #1's medical records on January 15, 2008, at approximately 2:35 PM revealed that Resident #1 did not have a wound care clinic consultation on file. In an interview with the House Manager on January 15, 2008 at approximately 2:40 PM it was acknowledged that Resident #1 had not received treatment from the wound care clinic as scheduled on December 11, 2007, because the facility did not have his Medicaid card when the resident was admitted on July 25, 2007. Further interview revealed that the facility was only able to obtain Resident#1's Medicaid card during the third week of December, 2007. The wound care appointment was re-scheduled for January 29, 2008. There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the wound care needs of the resident as required by his habilitation plan.</p> <p>3. Review of Resident #1's, physician's orders (POS) dated December 20, 2007 on January 15, 2008 at approximately 11:05AM revealed that the resident has a diagnosis of End Stage Renal Disease (ESRD). Review of Resident #1's, medical records on January 15, 2008 at approximately 11:08 AM revealed that the resident did not have a nephrology consult on file. In an interview with the House Manager on January 15, 2008 at approximately 11:10 AM it was acknowledged that Resident #1 had not been to the nephrologist because the facility did not have his Medicaid card when the resident was admitted on July 25, 2007. Further interview revealed that the facility was only able to obtain Resident#1's Medicaid card during the third week of December, 2007. There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to</p>	I 180	<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>I 180, 2 Cross Reference I 180, 1</p> <p>I 180, 3 Cross Reference I 180, 1</p> </div>	

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I 180	<p>Continued From page 4</p> <p>efficiently meet the nephrology needs of the resident as required by his habilitation plan.</p> <p>4. Review of Resident #1's, ophthalmology consult dated October 24, 2007 on January 15, 2008 at approximately 11:50AM revealed that the resident has a diagnosis of presbyopia. Review of Resident #1's medical records on January 15, 2008, at approximately 12:00 PM revealed that on October 24, 2007, the ophthalmologist prescribed eyeglasses for Resident #1. In an interview with the House Manager on January 15, 2007 at approximately 12:30 PM it was acknowledged that Resident #1 did not receive the prescribed eyeglasses because the facility did not have his Medicaid card when the resident was admitted on July 25, 2007. Further interview revealed that the facility was only able to obtain Resident#1's Medicaid card during the third week of December, 2007. There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the adaptive equiptive needs of the resident as required by his habilitation plan.</p> <p>5. Review of Resident #1's, medical records on January 15, 2008 at approximately 4:47 PM revealed that the resident did not have an audiology consult on file as ordered by the physician. In an interview with the House Manager on January 15, 2008 at approximately 4:50 PM it was acknowledged that Resident #1 had not been to the audiologist because the facility did not have his Medicaid card when the resident was admitted on July 25, 2007. Further interview revealed that the facility was only able to obtain Resident#1's Medicaid card during the third week of December, 2007. There was no documented evidence that the GHMRP ensured adequate administrative support had been</p>	I 180	<div style="border: 1px solid black; padding: 5px;"> <p>I 180, 4 Cross Reference I 180, 1</p> <p>I 180, 5 Cross Reference I 180, 1</p> </div>	

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I 180	<p>Continued From page 5</p> <p>provided to efficiently meet the audiology needs of the resident as required by his habilitation plan.</p> <p>6. Review of Resident # 4's, medical records on January 16, 2008 at approximately 4:48 PM revealed that the resident was not seen by the cardiologist on November 6, 2007 or on December 4, 2007 as ordered by the physician. In an interview with the House Manager on January 15, 2008 at approximately 4:55 PM it was acknowledged that Resident #4 had not been to the cardiologist because his Medicaid card was inactive. There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the cardiology needs of the resident as required by his habilitation plan.</p> <p>7. Review of Resident # 4's, medical records on January 16, 2008 at approximately 4:56 PM revealed that the resident did not have an audiology consult on file as ordered by the physician. In an interview with the House Manager on January 15, 2008 at approximately 4:58 PM it was acknowledged that Resident #4 had not been to the audiologist because his Medicaid card was inactive. There was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the audiology needs of the resident as required by his habilitation plan.</p>	I 180	<div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>I 180, 6 Cross Reference I 180, 1</p> <p>I 180, 7 Cross Reference I 180, 1</p> </div>	
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual</p>	I 222		

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I 227	Continued From page 7	I 227		
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four residents in the facility. (Resident #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) on January 16, 2008 at approximately 4:15 PM revealed that all staff was not trained in CPR. Record review on January 16, 2008 at approximately 4:20 PM revealed that one out of fourteen staff did not have a current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #1)</p> <p>2. Interview with the Qualified Mental Retardation Professional (QMRP) on January 16, 2008 at approximately 4:25 PM revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 4:30 PM revealed revealed that one out of fourteen staff did not have A current First Aid certification. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #1)</p>	I 227	<p>I 227 (1, 2) Staff #1 received training on CPR and First Aid on 02/12/08. As referenced in the statement of deficiencies, "one of the fourteen staff did not have a CPR and First Aid," it should be noted that the facility is always staffed with 3 employees, a nurse and two staff. This implies that at no point in time will performing CPR and First Aid be an issue.</p>	02/12/08
I 230	<p>3510.5(g) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p>	I 230		

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I 230	<p>Continued From page 8</p> <p>(g) Habilitation planning and Implementation;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for three of the four residents residing in the facility. (Resident #1, Resident #3 and Resident #4)</p> <p>The findings include:</p> <p>1. Review of Resident #1's IPP's dated September 2007 thru January 8, 2008, on January 15, 2008, at approximately 6:00 PM revealed an objective to tolerate range of motion (ROM) to the hips, knees, ankles and feet for sixteen repetitions daily for twelve months. Further record review revealed that staff was to document the amount of time the resident completed the exercises. The review of the data collection revealed that the staff had not documented in accordance with the instructions. The documented data only reflected the level of assistance needed as hand over hand. In an interview with the Qualified Mental Retardation Professional (QMRP), on January 15, 2008, at approximately 6:10 PM it was acknowledged that the staff were implementing the program as written but that there was a problem with the documentation. There was no evidence that the data had been collected in accordance with the IPP objective instructions which was necessary for a functional assessment of the resident's progress.</p> <p>2. Review of Resident #3's IPP's dated September 2007 thru January 8, 2008, on January 16, 2008, at approximately 7:30 PM</p>	I 230	<div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 80%;"> <p>I 230 (1, 2, 3, 4) Staff have been in-serviced on accurate data collection and documentation. During the in-service, emphasis was laid on documenting the time the resident completed the Range of Motion (ROM) exercises.</p> </div>	02/15/08

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I 230	<p>Continued From page 9</p> <p>revealed an objective to tolerate range of motion (ROM)of shoulders ,elbow, wrist and fingers, hips, knee, ankles and feet and the objective required five repetitions during each nursing shift. Further record review revealed that staff was to document the amount of time the resident completed each exercise. The review of the data collection revealed that the staff had not documented in accordance with the instructions. The documented data only reflected the level of assistance needed as hand over hand. In an interview with the QMRP on January 16, 2008, at approximately 7:35 PM it was acknowledged that the staff were implementing the program as written but that there was a problem with the documentation. There was no evidence that the data had been collected in accordance with the IPP objective instructions which was necessary for a functional assessment of the resident's progress.</p> <p>3. Review of Resident #4's IPP's dated November 2007, December 2007 and January 1-15, 2008 on January 16, 2008, at approximately 4:50 PM revealed an objective to tolerate 5/6 trials of ROM to the shoulders , elbow, wrist and fingers, hips, knees, ankles, feet, daily times twelve months. Further record review revealed that staff was to document the amount of time the resident completed each exercise. The review of the data collection revealed that the staff had not documented in accordance with the instructions. The documented data only reflected the level of assistance needed as hand over hand. In an interview with the QMRP, on January 16, 2008, at approximately 7:37 PM it was acknowledged that the staff were implementing the program as written but that there was a problem with the documentation. There was no evidence that the data had been collected in accordance with the</p>	I 230		

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I 230	<p>Continued From page 10</p> <p>IPP objective instructions which was necessary for a functional assessment of the resident's progress.</p> <p>4 . Observation on January 15, 2008, at approximately 7:00 PM revealed that the Licensed Practical Nurse (LPN) was performing ROM exercises with Resident #4. Review of Resident #4's IPP's dated November 2007, December 2007 and January 1-15, 2008 on January 16, 2008, at approximately 4:52 PM revealed an objective to complete lower extremity strengthening exercises three days a week for six months. Further record review revealed that staff was to document the amount of times the resident completed each exercise. The review of the data collection revealed that the staff had not documented in accordance with the instructions. The documented data only reflected the level of assistance needed as hand over hand. In an interview with the QMRP, on January 16, 2008, at approximately 7:39 PM it was acknowledged that the staff were implementing the program as written but that there was a problem with the documentation. There was no evidence that the data had been collected in accordance with the IPP objective instructions which was necessary for a functional assessment of the resident's progress.</p>	I 230		
I 261	<p>3512.2 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.</p> <p>This Statute is not met as evidenced by:</p>	I 261		

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I 261	<p>Continued From page 11</p> <p>Based on interview and record review the GHMRP failed to ensure records were available for inspection at all times by personnel of authorized regulator agencies.</p> <p>The findings include:</p> <p>1. On January 16, 2008, at approximately 10:30AM, Resident #2's Individual Support Plan (ISP) records were requested from the Qualified Mental Retardation Professional (QMRP), however the ISP records were not in the facility. In an interview with the QMRP on January 16, 2008 at approximately 10:45AM it was acknowledged that Resident #2's ISP records were not available for inspection during the survey. Review of an investigative report dated December 8, 2007 on January 16, 2008, at approximately 3:30 PM, revealed that the Office of the Inspector General (OIG) had removed the ISP records from the facility on November 30, 2007.</p> <p>2. On January 16, 2008, at approximately 10:35AM, Resident #2's medical records were requested from the QMRP, however only copies of the current physician's orders (POS), current Medication Administration Records (MAR's), current nursing notes, skin assessment sheets and a podiatrist consult dated November 25, 2007, were in the facility. In an interview with the QMRP on January 16, 2008 at approximately 10:50 AM it was acknowledged that Resident #2's entire medical records that included all of Resident #2's medical consultations were not available for inspection during the survey. Review of an investigative report dated December 8, 2007 On January 16, 2008, at approximately 3:30 PM, revealed that the OIG had removed the medical records from the facility</p>	I 261	<div style="border: 1px solid black; padding: 10px; width: fit-content;"> <p>I 261 (1, 2) The facility has been able to get copies of Resident #2's ISP records from the Department on Disability Services. An ISP book has been put in place. Past medical consults have been difficult to get from the Office of the Inspector General (OIG) pending an investigation. However a new medical book has been put in place which will account for future appointments.</p> </div>	02/01/08

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I 261	Continued From page 12 on November 30, 2007.	I 261		
I 262	<p>3512.3 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record and report that is required to be kept in accordance with this chapter shall be filed and retained for five (5) years by the GHMRP.</p> <p>This Statute is not met as evidenced by: Each record and report that is required to be kept in accordance with this chapter shall be filed and retained for five (5) years by the GHMRP.</p> <p>The findings include:</p> <p>1. On January 16, 2008, at approximately 10:30AM, Resident #2's Individual Support Plan (ISP) records were requested from the Qualified Mental Retardation Professional (QMRP), however the ISP records were not in the facility. In an interview with the QMRP on January 16, 2008 at approximately 10:45AM it was acknowledged that Resident #2's ISP records were not available for inspection during the survey. Review of an investigative report dated December 8, 2007 on January 16, 2008, at approximately 3:30 PM, revealed that the Office of the Inspector General (OIG) had removed the ISP records from the facility on November 30, 2007.</p> <p>2. On January 16, 2008, at approximately 10:35AM, Resident #2's medical records were requested from the QMRP, however only copies of the current physician's orders (POS), current Medication Administration Records (MAR's), current nursing notes, skin assessment sheets and a podiatrist consult dated November 25, 2007, were in the facility. In an interview with the</p>	I 262	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>I 262 (1, 2) Cross Reference I 261</p> </div>	

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I 262	Continued From page 13 QMRP on January 16, 2008 at approximately 10:50 AM it was acknowledged that Resident #2's entire medical records that included all of Resident #2's medical consultations were not available for inspection during the survey. Review of an investigative report dated December 8, 2007 On January 16, 2008, at approximately 3:30 PM, revealed that the OIG had removed the medical records from the facility on November 30, 2007.	I 262		
I 379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10).</p> <p>The finding includes: Review of an investigative report dated December 1, 2007 on January 16, 2008 at approximately 11:00 AM revealed that Resident #1 had reported to a family member on November 26, 2007, that a male direct care staff</p>	I 379	<div style="border: 1px solid black; padding: 5px;"> <p>I 379 In the future, the QMRP will, ensure that all incident reports are forwarded to the Department of Health on a timely manner. Staff have been trained on incident writing and reporting. Future trainings will be conducted quarterly.</p> </div>	02/15/08

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I 379	Continued From page 14 member had allegedly hit him in the facility on an unknown date. Interview with the Qualified Mental Retardation Professional (QMRP) on January 16, 2008, at 11:01 AM revealed that Resident #1 had not previously reported the incident to the facility staff. Further interview with the QMRP revealed that the completed unusual incident report was forwarded to the Department of Health (DOH). There was no documented evidence that this incident had been reported to the DOH as required. (Note: The allegation of abuse was unsubstantiated by the facility during their investigation.)	I 379			
I 391	3520.2(a) 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 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: (a) Medicine; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the goals and objectives of every individual habilitation plan for two of four residents in the	I 391			

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I 391	<p>Continued From page 15</p> <p>sample. (Resident #1, Resident #2 and Resident #3)</p> <p>The findings include:</p> <p>1. Review of an unusual incident reports dated January 10, 2008, revealed that Resident #1 was admitted to the hospital on January 10, 2008, because of a significant decrease in his Red Blood Count (RBC). Review of Resident #1's, physician's orders (POS) dated December 20, 2007 on January 15, 2008 at approximately 11:00AM revealed that the resident has a diagnosis of Diabetes Mellitus. Review of Resident #1's medical assessment dated September 6, 2007 on January 15, 2008 at approximately 12:50 PM revealed that laboratory studies had not been ordered to monitor the resident's psychotropic medications. Review of the Medication Administration Records (MARs) on January 15, 2008 at approximately 1:03 PM revealed that Resident #1 was prescribed Risperdal 0.25mg by mouth every day and Zoloft 50mg by mouth every day for depression. Review of the physicians orders dated December 20, 2007 on January 15, 2008 at approximately 1:01 PM revealed that the medications were prescribed for behavior management. In an interview with the Licensed Practical Nurse (LPN) on January 15, 2008, at approximately 1:05 PM it was acknowledged that laboratory studies had not been ordered to monitor the resident's psychotropic medications on the POS.</p> <p>2. Review of an unusual incident reports dated January 10, 2008, revealed that Resident #1 was admitted to the hospital on January 10, 2008, because of a significant decrease in his RBC. Review of Resident #1's medical assessment dated September 6, 2007 on January 15, 2008 at</p>	I 391	<div style="border: 1px solid black; padding: 5px;"> <p>I 391, 1 The POS for Resident # 1 was updated and now incorporates routine laboratory studies (CBC with diff, CMP, HGBA1C) that monitor side effects associated with psychotropic medications. However, Resident #1 had laboratory results as recent as 1/8/08 and 12/14/07 in his medical record at the time of this monitoring date which reflected these routine laboratory studies. (See attached results and POS)</p> </div>	02/01/08

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I 391	<p>Continued From page 17</p> <p>there were no psychotropic medication reviews for the months of September and October, 2007 in the record. There was no documented evidence that psychotropic medication reviews were in the medical record for the months of September/October, 2007.</p> <p>4. In an interview with the Qualified Mental Retardation Professional (QMRP) on January 16, 2008, at approximately 10:20 AM revealed that Resident #1 did not have a psychiatric evaluation on file in the facility. Review of the medical record on January 16, 2008 at approximately 10:21 PM revealed that Resident #1 did not have a psychiatric evaluation on file in his medical record. Review of Resident #1's, POS dated December 20, 2007, on January 15, 2008 at approximately 2:33 PM revealed that the resident has diagnoses of Depression D/O NOS, Dementia of Vascular Origin and Cognitive D/O NOS. Review of the January, MAR on January 15, 2008 at approximately 1:11 PM revealed that Resident #1 was prescribed Risperdal 0.25mg by mouth every day and Zoloft 50mg by mouth every day for depression and behavior management. There was no evidence of a psychiatric evaluation on file in the resident's medical record.</p> <p>5. Review of Resident #2's, physician's orders (POS) dated December 31, 2007, on January 16, 2008 at approximately 10:25 AM revealed that the resident was prescribed Lisinopril 10 mg by mouth every day for hypertension. Review of the January, MAR on January 16, 2008 at approximately 10:26 AM revealed that Resident #2 was prescribed Lisinopril 10 mg by mouth every day for hypertension. Review of Resident #2's, physician's orders (POS) dated December 31, 2007, on January 16, 2008 at approximately</p>	I 391	<div style="border: 1px solid black; padding: 5px;"> <p>I 391, 4 QMRP, RN and Psychiatrist will ensure that Resident #1 receives consistent psychiatric evaluation on an annual basis. Resident #1 is scheduled to receive an annual psychiatric assessment on 3/12/08.</p> </div> <p>I 391, 5 The POS for Resident # 2 was updated and now incorporates the diagnosis of hypertension. The RN will ensure that the LPN's will provide ongoing review of the POS in order to maintain accurate information.</p>	<p>03/12/08</p> <p>02/01/08</p>
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I 391	<p>Continued From page 18</p> <p>10:25 AM revealed that the resident's diagnosis of hypertension was not on the POS. In an interview with the LPN on January 15, 2008, at approximately 10:30 AM it was acknowledged that the resident's diagnosis of hypertension was not on the POS. There was no documented evidence that the resident's diagnosis of hypertension was on the POS.</p> <p>6. Review of Resident #2's, POS dated December 31, 2007, on January 16, 2008 at approximately 10:26 AM revealed that the resident was prescribed Accuzyme Ointment apply to right heel wound twice a day, Eurosol Gel apply to right heel wound twice a day and Allclerln Spray to cleanse right heel wound twice a day. Review of the January, MAR on January 16, 2008 at approximately 10:27 AM revealed that Resident #2 was prescribed Accuzyme Ointment apply to right heel wound twice a day, Eurosol Gel apply to right heel wound twice a day and Allclerln Spray to cleanse right heel wound twice a day for wound care. Review of Resident #2's, POS dated December 31, 2008, on January 16, 2008 at approximately 10:25 AM did not reveal that the resident had a diagnosis related to an alteration in skin integrity. In an interview with the LPN on January 16, 2008, at approximately 10:20 AM it was acknowledged that the POS did not reveal that the resident had a diagnosis related to an alteration in skin integrity. There was no documented evidence that the POS revealed that the resident had a diagnosis related to an alteration in skin integrity.</p> <p>7. Review of Resident #3's, POS dated December 20, 2007, on January 16, 2008 at approximately 6:40 PM revealed that the resident has a diagnosis of seizure disorder and is prescribed Keppra 10ml (1000 mg) via gastric</p>	I 391	<div style="border: 1px solid black; padding: 5px;"> <p>I 391, 6 Resident #2 does not have alteration in skin integrity on his POS, as this is a nursing diagnosis versus a medical diagnosis. His POS specifically indicates an ulcer to his right ischium area. Furthermore, his treatment regimen indicates the usage of Accuzyme ointment - apply to right ischium twice a day.</p> </div>	02/01/08

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I 391	Continued From page 19 tube twice a day and Valproic Acid 20 ml (1000 mg) via gastric tube twice a day. Review of a neurology consult dated August 2, 2007, revealed that the resident was to return to the neurology in two months. Interview with the Qualified Mental Retardation Professional (QMRP) on January 16, 2008 at approximately 6:42 PM revealed that the resident moved to the facility on October 1, 2007. Further review revealed that the Resident #2 will be scheduled for a neurology appointment. There was no documented evidence that Resident #2 returned to the neurology clinic or was scheduled for a neurology appointment. 8. Review of Resident #3's, medical record on January 16, 2008 at approximately 6:38 PM revealed that the resident did not have an audiology consult on file. In an interview with the House Manager on January 16, 2008 at approximately 6:39 PM it was acknowledged that Resident #3 had not been assessed by an audiologist. There was no documented evidence that Resident #3 was scheduled for an audiology appointment.	I 391	<div style="border: 1px solid black; padding: 5px;"> <p>I 391, 7 Resident # 2 is due to receive a neurology appointment on 3/21/08. The facilities RN will ensure that appointments are scheduled and adhered to in a timely manner. Furthermore, there was an in-service provided by the facility's RN on the importance of medical appointments.</p> </div>	03/21/08
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 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:	I 395	<div style="border: 1px solid black; padding: 5px;"> <p>I 391, 8 Resident # 3 is due to receive an audiology appointment on 6/10/08. The facility's RN will ensure that appointments are scheduled and adhered to in a timely manner. Furthermore, there was an in-service provided by the facilities RN on the importance of medical appointments.</p> </div>	06/10/08

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I 395	<p>Continued From page 20</p> <p>(e) Nursing:</p> <p>This Statute is not met as evidenced by: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team for four of four residents in the sample. (Resident #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. Review of Resident #1's, physician's orders (POS) dated December 20, 2007 on January 15, 2008 at approximately 11:00AM revealed that the resident has a diagnosis of Diabetes Mellitus. Review of Resident #1's, Medication Administration Records (MARs) dated December 2007 and January 1-9,2008 on January 15, 2008 at at approximately 2:10 PM revealed that the nursing staff failed to document the rotation of the insulin injection sites after administering Insulin Lantus (Glargine) 8 units subcutaneously every morning. In an interview with the Licensed Practical Nurse (LPN) on January 15, 2008, at approximately 2:16 PM it was acknowledged that the nursing staff failed to document the rotation of the insulin injection sites for Resident #1 after administering Insulin Lantus (Glargine) 8 units. There was no documented evidence that the nursing staff documented the rotation of the insulin injection sites after administering Insulin Lantus (Glargine) 8 units subcutaneously every morning.</p> <p>2. Review of Resident #1's, physician's orders (POS) dated December 20, 2007, on January 15, 2008 at approximately 2:30PM revealed that the</p>	I 395	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>I 395, 1 The facility's RN reviewed with the LPNs the importance of site rotation during administration of subcutaneous injections, and insulin shots.</p> </div> <p>I 395, 2 The facility's RN reviewed with LPNs the importance of wound measurement. Discussion and demonstrations were performed by the LPNs during the in-service.</p>	<p>02/01/08</p> <p>02/01/08</p>

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I 395	<p>Continued From page 21</p> <p>resident has diagnoses of left heel wound, right heel ulcer and bi-lateral gangrene of the feet. Review of Resident #1's, Skin Assessment Sheets dated January, 2008, October 1-7, 2007 and October 13-31, 2007 on January 15, 2008 at approximately 2:40 PM revealed that the Stage II wounds on the left and right heels were not measured. Review of the Health Management Care Plan (HMCP) dated August 27, 2007, on January 15, 2008 at approximately 2:42 PM recommended to measure size and depth of open wounds weekly and record on wound care document. In an interview with the LPN on January 15, 2008, at approximately 2:45 PM it was acknowledged that the Stage II wounds on the left and right heels were not measured as recommended by the HMCP. There was no documented evidence that the Stage II wounds on the left and right heels were measured as recommended by the HMCP.</p> <p>3. Review of Resident #1's, nutritional assessment dated August 20, 2007, on January 15, 2008 at approximately 4:18 PM revealed that the resident weighed 153.7 pounds when admitted to the facility on July 25, 2007. Further review revealed that the resident's Ideal Body Weight (IBW) was 123-165 pounds. Review of Resident #1's, weight chart on January 15, 2008 at approximately 4:20 PM revealed that on August 1, 2007 the resident's recorded weight was 162 pounds (weight gain of 8.3 pounds); on October 9, 2007 the resident's recorded weight was 163.4.7 pounds and on November 2, 2007 the resident's recorded weight was 168.8 pounds (weight gain of 5.4 pounds); on December 1, 2007 the resident's recorded weight was 170.7 pounds and on January 5, 2008 the resident's recorded weight was 186.2 pounds (weight gain of 15.5 pounds). Interview with the Qualified</p>	I 395		

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I 395	<p>Continued From page 22</p> <p>Mental Retardation Professional (QMRP) and the LPN on January 15, 2008 at approximately 4:20 PM, revealed that the nursing staff may be calculating the weight of Resident #1 and the weight of his wheelchair incorrectly, which would account for the resident's weight gain. There was no documented evidence that the nursing staff informed the PCP or the nutritionist of the resident's gain in weight.</p> <p>4. Review of an unusual incident report dated January 10, 2008, revealed that Resident #2 was admitted to the hospital on January 9, 2008, for Review of an unusual incident report dated January 10, 2008, Resident #2 was admitted to the hospital on January 9, 2008, for wound care treatment. Review of an undated wound protocol document for Resident #2 on January 16, 2008 at approximately 10:53 AM revealed a recommendation to measure size and depth of open wounds weekly and record on wound care document. Review of Resident #2's, Skin Assessment Sheets dated November 27, 2007-December 3, 2007, on January 16, 2008 at approximately 11:00 AM revealed that the Stage II wound on the right ankle was not measured. Review of Resident #2's, Skin Assessment Sheets dated November 1, 2007- November 18, 2007, on January 16, 2008 at approximately 11:04 AM revealed that the Stage III wound on the right heel was not measured. Review of Resident #2's, Skin Assessment Sheets dated November 19, 2007- December 5, 2007, on January 16, 2008 at approximately 11:04 AM revealed that the pressure ulcer on the right buttocks was not measured. In an interview with the Supervisory Registered Nurse (RN) on January 16, 2008, at approximately 5:40 PM it was acknowledged that the Stage II wound on the right ankle, Stage III wound on the right hael and</p>	I 395	<div style="border: 1px solid black; padding: 5px;"> <p>I 395, 3 The facility's RN reviewed the importance of weight management with the LPNs. Additionally; the facility's RN will hold training on this subject matter on 2/22/08 with all Wholistic LPNs.</p> <p>I 395, 4 Cross Reference I395, 2.</p> <p>I 395, 5 Cross Reference I395, 2.</p> </div>	02/22/08

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I 395	<p>Continued From page 23</p> <p>the pressure ulcer on the right buttocks was not measured according to the wound protocol. There was no documented evidence that the Stage II wound on the right ankle, Stage III wound on the right heel and the pressure ulcer on the right buttocks was measured according to the wound protocol.</p> <p>5. Review of an undated wound protocol document for Resident #3 on January 16, 2008 at approximately 6:10 PM revealed a recommendation to measure size and depth of open wounds weekly and record on wound care document. Review of Resident #3's, Skin Assessment Sheets dated December, 2007-January 1-14, 2008, on January 16, 2008 at approximately 6:15 PM revealed that the Stage III wound on the right buttocks was not measured. In an interview with the LPN on January 16, 2008, at approximately 6:17 PM it was acknowledged that the Stage III wound on the right buttocks was not measured according to the wound protocol. There was no documented evidence that the Stage III wound on the right buttocks was measured according to the wound protocol.</p>	I 395		
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, facility's nursing services failed to ensure timely</p>	I 401		

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I 401	<p>Continued From page 26</p> <p>recommended by the PCP.</p> <p>2. Review of Resident #1's HMCP dated August 27, 2007 on January 15, 2008 at approximately 3:25 PM revealed that the HMCP had not been updated to include the resident's diagnoses of Peripheral Vascular Disease (PVD), Benign Prostatic Hypertrophy (BPH), and bi-lateral dry gangrene of the feet. In an interview with the LPN on January 15, 2008 at approximately 3:27 PM it was acknowledged that the HMCP had not been updated to include the resident's diagnoses of PVD, BPH, and bi-lateral dry gangrene of the feet. There was no documented evidence that the HMCP had been updated after August 27, 2007 to include the diagnoses of PVD, BPH, and bi-lateral dry gangrene of the feet.</p> <p>3. Review of an unusual incident report dated January 10, 2008, revealed that Resident #2 was admitted to the hospital on January 9, 2008, for wound care treatment. Review of Resident #2's HMCP dated October 29, 2007 on January 15, 2008 at approximately 6:50 PM revealed that the HMCP had not been updated to include the resident's wound care protocol. In an interview with the LPN on January 16, 2008 at approximately 6:52 PM it was acknowledged that the HMCP had not been updated to include the resident's resident's wound care protocol. There was no documented evidence that the HMCP had been updated after October 29, 2007, to include the resident's wound care protocol.</p> <p>4. Review of Resident #1's medical records on January 15, 2008 at approximately 3:30 PM revealed that the quarterly nursing assessment was not on file for December 2007. In an interview with the LPN on January 15, 2008 at approximately 3:32 PM it was acknowledged that</p>	I 401	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>I 401, 3 The HMCP was updated by the facility's RN to include the implementation of care pertaining to Resident #2's nursing diagnosis of altered skin integrity, which in turn incorporates the wound care protocol.</p> </div>	02/01/08
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I 401	<p>Continued From page 26</p> <p>the the quarterly nursing assessment was not on file for December 2007. There was no documented evidence that the quarterly nursing assessment was on file for December 2007.</p> <p>5. Review of Resident #1's POS dated September 6, 2007 on January 15, 2008 at approximately 1:35 PM revealed an order to administer Keflex 250 mg three times a day by mouth for two weeks. Review of the Medication Administration Record (MAR) dated December 1, 2007 on January 15, 2008 at approximately 1:36 PM revealed that documentation relating to the administration of Keflex 250 mg by mouth was crossed out without being initialed on the MAR from September 22, 2007, at 7:00 AM to September 26, 2007, at 7:00 AM and on September 28, 2007, at 7:00 AM. Further review revealed that documentation relating to the administration of Keflex 250 mg by mouth was crossed out without being initialed on the MAR from September 22, 2007, at 12:00 noon to September 25, 2007, at 12:00 noon and on September 22, 2007, at 7:00 PM to September 25, 2007, at 7:00 PM. In an interview with the LPN on January 15, 2008 at approximately 1:38 PM it was acknowledged that the nursing staff crossed out documentation without initialing the entries according to the Principles of Nursing Documentation from September 22-28, 2007. There was no evidence that the nursing staff documented on the MAR according to the Principles of Nursing Documentation.</p> <p>6. Review of Resident #4's POS dated September 27, 2007 on January 16, 2008 at approximately 1:34 PM revealed an order to administer Keflex 250 mg/5ml. three times a day times 10 days. Review of the Medication Administration Record (MAR) dated October</p>	I 401	<p>I 401, 4 The facility's RN has completed a nursing quarterly for Resident #1.</p> <p>I 401, 5 There was an in-service performed on 02/01/08 on the importance of adhering to the standards of nursing documentation. The said error was previously noted by the facility's RN. The RN will continue to provide ongoing training on the standards of nursing documentation.</p>	02/01/08

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1401	<p>Continued From page 27</p> <p>3-12, 2007 on January 16, 2008 at approximately 1:36 PM revealed that the medication was not obtained and administered until October 3, 2007. In an interview with the Supervisory Registered Nurse (RN) on January 16, 2008 at approximately 2:38 PM it was acknowledged that the nursing staff did not obtain the Keflex 250 mg/5ml until October 3, 2007. Further interview revealed that the facility usually has a two day turn around to obtain and administer perscribed medications. There was no evidence that the nursing staff obtained and administered the medication until October 3, 2007.</p>	1401	<div style="border: 1px solid black; padding: 5px;"> <p>I 401, 6 The facility's RN reviewed with the LPNs on the internal policy of the turnaround period for obtaining and administering medications. Furthermore, the facility's RN will provide ongoing training and oversight of this policy with the LPNs.</p> </div>	02/01/08
1420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for two of four residents in the sample. (Resident #1 and Resident #4)</p> <p>The findings include:</p> <p>1. Review of the dermatologist's consult dated November 16, 2007 on January 16, 2008 at approximately 5:20 PM revealed that Resident #1 was recommended to have Eucerin Cream applied to the body after bathing. In an interview</p>	1420		

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I 420	<p>Continued From page 28</p> <p>with the House Manager on January 16, 2007 at approximately 5:30 PM it was acknowledged that Resident #1 had ran out of Eucerin Cream and it was to be ordered from the pharmacist. There was no evidence that the facility provided Eucerin Cream for Resident #1 as recommended by the dermatologist.</p> <p>2. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the Occupational Therapist's (OT) recommendation for Resident # 1 was addressed as evidenced by:</p> <p>Environmental observation on January 15, 2008 at approximately 3:00 PM revealed a shower chair with stationary armrests in the bathroom on the first floor hallway. Review of Resident #1's physician's order sheet (POS) dated December 1, 2007 on January 15, 2008 at approximately 3:15 PM revealed that the resident had contractures of the hands and feet. Review of the OT assessment dated August 12, 2007 on January 15, 2008 at approximately 3:36 PM revealed that Resident #1 was recommended to be considered for a shower chair with a removable armrest to assist with safer transfers. There was no documented evidence that the OT's recommendation was addressed by the IDT.</p> <p>3. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the Psychologist's recommendation for Resident # 4 was addressed as evidenced by:</p> <p>Review of Resident #4's physician's order sheet (POS) dated December 20, 2007 on January 16, 2008 at approximately 1:20 PM revealed that the resident had an Axis I diagnosis of Schizophrenia. Review of the Psychologist's</p>	I 420	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>I 420, 1 Resident #1 has Eucerin cream available in the home. Additionally, staff received training on how to request for new treatments that have expired.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>I 420, 2 A request has been placed with the maintenance division for the stationary armrest shower chair to be replaced by a removable armrest shower chair</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>I 420, 3 Resident #4 is schedule to see the Psychiatrist on 03/12/08 to address the psychologist's recommendation.</p> </div> <p>I 420, 4 Cross Reference I 420, 2.</p>	<p>02/01/08</p> <p>02/15/08</p> <p>03/12/08</p>

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1 420	<p>Continued From page 29</p> <p>assessment dated September 15, 2007 on January 16, 2008 at approximately 3:36 PM revealed a recommendation requesting that the Psychiatrist rule out the Axis I diagnosis of Schizophrenia due to the absence of psychiatric symptoms for a long period of time and that the resident is not on any psychotropic medications. In an interview with the QMRP on January 16, 2008 at approximately 3:45 PM it was acknowledged that the Psychologist's recommendation had not been addressed by the IDT. There was no documented evidence that the Psychologist's recommendation was addressed by the IDT.</p> <p>4. The QMRP failed to coordinate services with the Interdisciplinary Team IDT to ensure that the OT recommendation for Resident # 4 was addressed as evidenced by:</p> <p>Environmental observation on January 15, 2008 at approximately 3:00 PM revealed a shower chair with stationary armrests in the bathroom on the first floor hallway. Review of Resident #4's physician's order sheet (POS) dated December 20, 2007 on January 16, 2008 at approximately 1:35 PM revealed that the resident had a Cerebral Vascular Accident with right sided weakness. Review of the OT assessment dated September 13, 2007 on January 16, 2008 at approximately 3:51 PM revealed that Resident #4 was recommended to be considered for a shower chair with removable armrest to assist with safer transfers. There was no documented evidence that the OT's recommendation was addressed by the IDT.</p> <p>5. The QMRP failed to coordinate services with the Recreational Therapist (RT) to ensure that a complete RT assessment was conducted in 30 days for Resident #4 as evidenced by:</p>	1 420		

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I 420	Continued From page 30 Review of the RT's assessment dated September 23, 2007 on January 16, 2008 at approximately 3:56 PM revealed that a complete RT assessment would be conducted in preparation of Resident #4's 30 day review. In an interview with the QMRP on January 16, 2008 at approximately 4:00 PM it was acknowledged that the RT did not submit the complete RT assessment. There was no documented evidence that the complete RT assessment was conducted in preparation for the 30 day review.	I 420	I 420, 5 In the future, the QMRP will ensure that comprehensive assessments are done and submitted prior to a review.	02/01/08
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure habilitation and training on oral hygiene was provided for one of four residents in the sample. (Resident #1) The finding includes: Review of the Primary Care Physician's orders dated July 26, 2007, on January 15, 2008 at approximately 1:50 PM revealed that revealed a recommendation that the resident brush his teeth twice a day. Review of a dental consult dated November 28, 2007, revealed that resident was diagnosed with moderate calculus and that he needed scaling. Interview with the Qualified Mental Retardation Professional (QMRP) on	I 432	I 432 Resident #1's tooth brushing program was not specified in his ISP. However, the treatment record in the Medical Administration Record clearly specifies mouth care which includes tooth brushing. Mouth care is done on every shift which adds up to three times per day. The House Manager will continue to monitor staff to ensure that tooth brushing is done on every shift.	02/01/08

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1432	<p>Continued From page 31</p> <p>January 15, 2007 at approximately 5:44 PM revealed that direct care staff supervise/assist the resident in brushing his teeth in the AM and PM. Review of the Individual Support Plan (ISP) dated August 27, 2007, on January 15, 2008 at approximately 5:45 PM revealed that direct revealed that the Resident #1 did not have a tooth brushing program. There was no evidence that the resident was brushing his teeth two to three times daily as prescribed by the PCP.</p>	1432		
1473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident 's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that any irregularities in the drug regimen for two of four residents in the sample was reported to the prescribing physician. (Resident #1 and Resident #3)</p> <p>The findings include:</p> <p>1. Review of Resident #1's, physician's orders (POS) dated December 20, 2008 on January 15, 2007 at approximately 11:00AM revealed that the resident has a diagnosis of Diabetes Mellitus. Review of the physician's order sheet (POS) dated December 20, 2007 on January 15, 2008 at approximately 2:20 PM revealed an order to administer Novolin R Regular Insulin (Insulin Human R-U-100) based on the results of glucose fingersticks on a sliding scale before meals and at bedtime. Further review revealed that Resident #1 was to be administered 4 units of Novolin R Regular Insulin on a sliding scale for glucose fingerstick levels between 201-250.</p>	1473		

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If continuation sheet 32 of 38

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I 473	Continued From page 32 Review of the Medication Administration Record (MAR) dated December, 2007 on January 15, 2008 at approximately 1:33 PM revealed that Resident #1 was not administered any units of Novolin R Regular Insulin on December 17, 2007, at 12:00 noon for a glucose fingerstick level of 234. In an interview with the Licensed Practical Nurse (LPN) on January 10, 2008 at approximately 12:01PM it was acknowledged that Resident #1 was not administered any Novolin R Regular Insulin for a glucose level of 234. There was no evidence that the physician was informed that the medication was not given in compliance with the physician's orders. 2. Review of Resident #1's, physician's orders (POS) dated December 20, 2008 on January 15, 2007 at approximately 11:00AM revealed that the resident has a diagnosis of Diabetes Mellitus. Review of the physician's order sheet (POS) dated December 20, 2007 on January 15, 2008 at approximately 2:20 PM revealed an order to administer Novolin R Regular Insulin (Insulin Human R-U-100) based on the results of glucose fingersticks on a sliding scale before meals and at bedtime. Further review revealed that Resident #1 was to be administered 2 units of Novolin R Regular Insulin on a sliding scale for glucose fingerstick levels between 151-200. Review of the MAR dated January, 2008 on January 15, 2008 at approximately 1:34 PM revealed that Resident #1 was administered Novolin R Regular Insulin 4 units on January 5, 2008, at 12:00 noon for a glucose fingerstick level of 156. In an interview with the LPN on January 10, 2008 at approximately 12:02 PM it was acknowledged that Resident #1 was administered 4 units of Novolin R Regular Insulin for a glucose level of 156 instead of the prescribed 2 units. There was no evidence that	I 473	<div style="border: 1px solid black; padding: 5px;"> <p>I 473, 1 The facility's RN reviewed the 5 rights of medication administration with the LPNs. Additionally, the protocol on when to notify the physician was also reviewed. The RN will hold training on this subject matter on 2/22/08 with all Wholistic LPN's.</p> <p>I 473, 2 Cross Reference I473, 1</p> </div>	02/22/08

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1473	Continued From page 33 the physician was informed that the medication was not given in compliance with the physician's orders. 3. Review of the Resident #1's physician's order sheet (POS) dated September 6, 2007 on January 15, 2008 at approximately 1:35 PM revealed an order to administer Keflex 250 mg three times a day by mouth for two weeks. Review of the Medication Administration Record (MAR) dated December 1, 2007 on January 15, 2008 at approximately 1:36 PM revealed documentation that Resident #1 was administered Keflex 250 mg by mouth from September 7, 2007 19, 2007 at 7:00 PM to September 22, 2007, at 7:00 PM. In an interview with the Licensed Practical Nurse (LPN) on January 10, 2008 at approximately 1:46PM it was acknowledged that Keflex 250 mg by mouth three times a day was not to be administered after September 21, 2007. Further interview acknowledged that Keflex 250 mg by mouth three times a day was documented on the MAR, revealing that Resident #1 received Keflex 250 mg by mouth on September 22, 2007 at 7:00 PM. There was no evidence that the physician was informed that the medication was not given in compliance with the physician's orders. 4. Review of Resident #3's physician's order sheet (POS) dated November, 2007 on January 16, 2008 at approximately 7:00 PM revealed an order to discontinue Aricept 5 mg via gastric tube every evening. Review of the Medication Administration Record (MAR) dated November, 2007 on January 16, 2008 at approximately 7:02 PM revealed that Resident #3 was administered Aricept 5 mg via gastric tube from November 2-30, 2007. In an interview with the LPN on January 16, 2008 at approximately 7:15 PM it was	1473	I473, 3 Cross Reference I473, 1 I473, 4 Cross Reference I473, 1 I473, 5 Cross Reference I473, 1		

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1473	Continued From page 34 acknowledged that Aricept 6 mg was administered from November 2-30, 2007, according to the MAR. There was no evidence that the physician was informed that the medication was not given in compliance with the physician's orders. 5. Review of Resident #3's, POS dated October 24, 2007, on January 16, 2008 at approximately 6:40 PM revealed that the resident was prescribed Valproic Acid 20 ml (1000 mg) via gastric tube three times a day times ten days. Review of the Medication Administration Records (MARs) dated October 24, 2007 thru November 2, 2007 on January 16, 2008 at approximately 7:02 PM revealed that Resident #3 was not administered Valproic Acid 20 ml via gastric tube on November 2, 2007 at 12:00 noon and 7:00 PM. In an interview with the LPN on January 16, 2008 at approximately 7:15 PM it was acknowledged that Resident #3 was not administered Valproic Acid 20 ml via gastric tube on November 2, 2007 at 12:00 noon and 7:00 PM according to the MAR. There was no evidence that the physician was informed that the medication was not given in compliance with the physician's orders. 6. Review of Resident #3's physician 's orders dated December 20, 2007, revealed an order to administer Prevacid DR U-D 30mg via gastric tube every day for GERD. Review of the Medication Administration Record (MAR) dated October, 2007 on January 16, 2008 at approximately 7:02 PM revealed that Resident #3 was not administered Prevacid DR U-D 30mg via gastric tube from October 28-30, 2007, because the medication was not available. In an interview with the LPN, on January 16, 2008 at approximately 7:04 PM it was acknowledged that	1473			

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1473	Continued From page 35 the medication was not available in the facility according to the MAR. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders. 7. Review of Resident #3's physician's orders dated December 20, 2007, revealed an order to administer Vitamin C, 5 ml. via gastric tube twice a day. Review of the Medication Administration Record (MAR) dated October, 2007 on January 16, 2008 at approximately 8:40 PM revealed that Resident #3 was not administered Vitamin C, 5 ml. via gastric tube twice a day from October 20-27, 2007, because the medication was not available. In an interview with the LPN on January 16, 2008 at approximately 6:42 PM, it was acknowledged that the medication was not available in the facility according to the MAR. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders. 8. Review of Resident #3's physician's orders dated December 20, 2007, revealed an order to administer Prozac 5 ml. via gastric tube every evening. Review of the Medication Administration Record (MAR) dated October, 2007 on January 16, 2008 at approximately 7:02 PM revealed that Resident #3 was not administered Prozac 5 ml. via gastric tube every evening from October 18-26, 2007, because the medication was not available. In an interview with the LPN, it was acknowledged that the medication was not available in the facility according to the MAR. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders.	1473	<div style="border: 1px solid black; padding: 5px;"> <p>I473, 6 Cross Reference I473, 1</p> <p>I473, 7 Cross Reference I473, 1</p> <p>I473, 8 Cross Reference I473, 1</p> </div>		