

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

BNO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2007
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1938 FIRST STREET NW WASHINGTON, DC 20001
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W 000	INITIAL COMMENTS A recertification survey was conducted from March 27, 2007 through March 29, 2006. The survey was initiated using the fundamental survey process. A sample of four clients was selected from a resident population of eight men with various disabilities.	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The findings of the survey were based on observations and staff interviews in the home and at three day programs, interview with two clients' legal guardians, as well as a review of client and administrative records, including incident reports. The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that Client #1's record accurately documented the status of the guardianship/ conservator services that were established for protecting his rights. The findings include: On March 27, 2007, at 8:37 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 had a court-appointed guardian. The guardian was interviewed by telephone on March 28, 2007, beginning at 1:52 PM. She confirmed that she was his guardian. Review of Client #1's records, beginning at 3:00 PM on March 28, 2007, revealed the following:	W 111		

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 2007 APR 24 P 3:40

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gmery Styshu</i>	TITLE <i>President</i>	(X6) DATE <i>4/19/07</i>
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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 111	<p>Continued From page 2</p> <p>or conservator. The interview also revealed that the QMRP, who had primary responsibility in preparing the client's annual ISP, was unsure of the roles and responsibilities of the guardian and conservator, as follows:</p> <p>a. He said he thought the cousin might have "limited medical" guardianship. While being interviewed, the QMRP looked through the group home office for documentation that would define the guardian's role and responsibility. At 9:05 AM, the QMRP presented court documents that indicated the cousin was appointed as "general guardian," effective 3/13/03.</p> <p>b. At 9:09 AM, the QMRP presented a document prepared by the conservator, dated March 2004, that was submitted to the court. The document did not clearly state the role and responsibility assigned by the court. The QMRP said the conservator had ceased contacting the client and the group home a few years earlier because the client had no assets. The appointment reportedly was based on the need to handle the sale of a relative's home. To his knowledge, the home had never been sold; therefore the client remained without assets. The home reportedly was in disrepair and possibly slated for demolition. The client's record did not contain any documentation needed to verify the information being presented through interview.</p> <p>c. The QMRP stated that he had discussed the issue (sale of the family home) with the guardian; however, he acknowledged that those conversations had not been documented in the client's record.</p> <p>d. The QMRP acknowledged that he had not</p>	W 111 a & b c & d	<p>QMRP was given an In-service on record keeping on 04-16-07.</p> <p><i>Attachment 'c'</i></p> <p>QMRP will document all pertinent conversations in the client's Active Medical Record and as of 04-16-07</p>	<p><i>4-16-07</i></p> <p><i>4-16-07</i></p>

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W 111	<p>Continued From page 3</p> <p>called the conservator in recent years. He further indicated that the conservator's role and responsibility had not been discussed by the client's interdisciplinary team.</p> <p>e. The QMRP was of the understanding that Client #1's guardian was submitting semi-annual status reports to the court. Filing 6-month reports reportedly was mandated by the court. There were no status reports, however, available for review in the client's record. The QMRP said he would need to follow-up with the guardian to confirm that she has been filing reports, as mandated and to request that the client receive copies for inclusion in his record.</p> <p>2. The facility failed to update Client #4's medical record to reflect the status of a hospital pathology report.</p> <p>Review of incident reports on March 27, 2007, at 3:12 PM, revealed that a foreign body was surgically removed from Client #4's stomach on January 8, 2007. On January 9, 2007, a group home nurse wrote the following progress note: "... Per PMD talk with medical team to <sic> Georgetown University Hospital a plastic piece was removed from the stomach and was sent to pathology..." On the hospital discharge summary, the hospital physician wrote the following: "Large foreign body in stomach." The hospital provided no additional descriptive information regarding the object that was removed. Review of the incident report, investigation report, primary care physician's notes, nursing notes and other aspects of Client #4's record failed to indicate the nature of the plastic object (size, color, etc.).</p> <p>When interviewed on March 28, 2007, at</p>	W 111	<p>e. All reports submitted to court by guardian will be field in the Active Medical Record as of 4-16-07.</p> <p><i>See attachment 01-04</i></p> <p>2. DCHC has requested the pathology report from [REDACTED]. Since the report has not been received the details of the plastic object have not been updated in the client's record. (Please see attachment) E1 + E2.</p>	<p>04-16-07</p> <p>4-17-07</p>

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W 111	Continued From page 4 approximately 9:36 AM, the Qualified Mental Retardation Professional indicated that he was unaware of whether the nurses or primary care physician had requested the results of the hospital pathology lab investigation. Review of Client #4's record on March 29, 2007 failed to show evidence that the hospital pathology lab had sent the results of their evaluation of the object. In addition, the client's nursing notes did not reflect follow-up with the hospital to obtain the results. Interview with the Director of Nursing (DoN) on March 29, 2007 indicated that a facility nurse had indeed telephoned the hospital sometime after the incident (date not specified). The DoN recalled the nurse having been told by the hospital that the plastic object had not been sent to pathology. However, the telephone call was not reflected in the client's record.	W 111		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate the source and nature of a "foreign body" that was surgically removed from the stomach of one of the four clients in the sample. (Client #4) The finding includes: Review of incident reports on March 27, 2007, at 3:12 PM, revealed that Client #4 had gone to the	W 154	- Pertinent telephone calls will be documented in the Active Medical record from 04-16-07 onwards.	4-16-07

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W 154	Continued From page 5 hospital for a routine endoscopy and colonoscopy on January 8, 2007 to rule out GERD. In a progress note dated January 9, 2007, the client's primary care physician wrote the following: "foreign body, round plastic piece, was removed by laparoscopic gastrostomy through a small incision in the abdomen without complications yesterday." According to a group home nursing progress note dated January 9, 2007, the plastic piece "was removed from the stomach and was sent to pathology." Attached to the incident report was an investigation report, dated January 11, 2007 re: "Emergency Inpatient Hospitalization." The investigation report documented that the Qualified Mental Retardation Professional (QMRP) was interviewed on January 8, 2007. The QMRP recounted the initial discovery of the foreign body and its surgical removal. There was no evidence that the QMRP was asked how the client might have ingested the plastic object (when, where, how, etc.). There were no additional interviews indicated in the investigative report. Further review of the investigative report failed to reflect whether the facility had sought to determine the source or nature of the plastic object. [Also see W111]	W 154	This deficiency was reviewed with the incident management investigator, and was asked to cover all areas of "how, when, where, what" question to complete a thorough investigation report. The incident management investigator Will continue to attend DDS incident management training as scheduled by DDS.	04-17-07 Ongoing	04-17-07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 252			

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W 252	Continued From page 6 review, the facility failed to ensure data relative to the accomplishment of the behavioral objective for one of four clients in the sample (Client #4) was documented in measurable terms. The finding includes: On March 28, 2007 at 4:25 PM, Client #4 was observed to be agitated and noisy. He was escorted to the back porch by staff where he continued to be agitated. As staff attempted to calm the client, the client pulled off his shirt. Staff continued to talk to the client and assisted him back into his shirt. Interview with staff revealed disrobing is one of the client's targeted behaviors. The review of Client #4's Behavior Support Plan (BSP) dated February 20, 2007 revealed an objective which states the client "will decrease clothes stripping to two or fewer occurrences per month for nine months." Interventions include documentation of all occurrences of disrobing on the behavior data collection forms in the individual program plan book. Record verification on March 29, 2007 at 12: 17 PM revealed no evidence the aforementioned disrobing behavior exhibited by Client #4 on March 28, 2007 was documented.	W 252	Staff members were Re-in serviced on data collection behavior support plan, behavior documentation on 04-13-07. (See attachment) F1	4-13-07	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that prescribed medication was administered as prescribed, for one of the four clients in the sample. (Client #1)	W 369			

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W 369	Continued From page 7 The findings include: The morning medication administration pass was observed on March 27, 2007, beginning at 7:04 AM. At 7:20 AM, the Licensed Practical Nurse (LPN) was observed administering Client #1's medications. The LPN left the facility shortly after 8:05 AM. According to Client #1's March 2007 Medication Administration Record (MAR) and physician's orders (POs), the nurse was to have administered one tablet of Allegra D-24 Hour allergy medication. At no time was Client #1 observed receiving Allegra D-24. It should be noted that review of Client #1's MAR on March 27, 2007, at approximately 10:45 AM, revealed that the medication nurse had mistakenly recorded having administered the Allegra D-24 on March 27, 2007.	W 369	The medication administration Nurse was in-serviced by DON & PMD on 04-03-07 The medication nurse was also reprimanded for the same. <i>Attachment 'G'</i>	04-03-07	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve each foods in a form consistent with the prescribed texture for one of the four clients (Client #4) in the sample. The finding includes: On March 28, 2007 at 4:10 PM Client #4 was offered a choice of snacks from a tray. Client #4 was observed to select a Twinkie (Cake). Staff removed the wrapper for the client, mashed the Twinkie, then gave it to the client who hurriedly ate it with a spoon. The review of the bulletin	W 474			

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W 474	Continued From page 8 board in the kitchen revealed an undated document written by the dietitian which was posted for staff attention. These guidelines stated if the diet order is pureed diet, please puree all solid foods. The guidelines further stated all kinds of bread need to be pureed. Interview with staff and the review of the meal pattern posted for the client in the kitchen revealed the client is prescribed a 3000 calorie, Low Cholesterol High Fiber, Pureed Diet. Record verification revealed a physician's order dated January 1, 2007 which stated the client was prescribed a 3000 calorie, Low Cholesterol, High Fiber, Pureed Diet. According to an undated mealtime protocol for Client #4 (Cautions and other notations), all solid foods (meat, bread, starch, fruits, vegetables, snacks and desserts should be pureed. There was no evidence that Client #4 received each food in the pureed consistency prescribed.	W 474	Staff was re-inserviced on 04-13-07 to follow diet orders- special diet protocols etc. <i>Attachment 'H'</i>	4-13-07	
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients allowed to assist in the kitchen were provided an opportunity to participate in family style dining for three of the eight clients in the survey. (Clients #1, #6 and #8) The finding includes: Interview with the staff preparing the food on March 28, 2007 at 5:53 PM indicated that Clients	W 488			

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W 488	<p>Continued From page 9</p> <p>#1, #6, and #8 were able to assist in the kitchen during various task such as loading the dishwasher and carrying eating utensils, glasses and place mats to the table. The clients, however, required supervision and prompting. At 6:18 PM, staff was observed serving the food onto each of the clients' plates. The Qualified Mental Retardation Professional (QMRP) was observed reading the portions required for the various diets to the staff. The plates for the clients were then carried to the dining room table where the clients ate their meal. After dinner, Client #8 was observed loading the dishwasher as staff rinsed the plates and passed them to him.</p> <p>Interview with the QMRP concerning the clients' ability to help serve their own plates indicated that Clients #1, #6, and #8 could possibly participate in family style dining if they were provided training and assistance. There was no evidence however that the clients were provided an opportunity to participate in family style dining or that learning opportunities were provided for them to select the appropriate type and amounts of foods at mealtime.</p>	W 488	<p>An in-service was done on 04-16-07 to encourage family style dining for clients 1, 6 & 8. Learning opportunities will be given to them at meal time. The training will start with vegetables, fruits and beverages.</p> <p><i>Attachment I</i></p>	04-16-07	

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1 000	INITIAL COMMENTS A licensure survey was conducted from March 27, 2007 through March 29, 2006. A random sample of four residents was selected from a resident population of eight men with various degrees of disabilities. The findings of this survey were based on observations at the group home and three day programs, interviews with two legal guardians, day program and residential staff, and the review of clinical and administrative records, including incident reports.	1 000		
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Observation of the environment were conducted on March 29, 2007 beginning at 2:10 PM facility failed to maintained the environment as evidence by the concerns identified below: 1. Exterior of the facility: a. On March 29, 2007 at approximately 2:45 PM, the left lid on the dumpster located in the back yard was observed open and with trash piled above the top. Interview with the staff revealed the trash would be removed on the next day, which was one of the two days a week trash was collected. Further interview with the staff indicated no other trash can was available to collect trash when the dumpster was full. There	1 090	a. An extra toter was ordered on 04-17-07. So that extra trash can be stored and picked up by the same trash removal company.	4-17-07

Health Regulation Administration

Gorney Stephen

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

TITLE

President

(X6) DATE

4/19/07

STATE FORM

5899

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I 090	Continued From page 1 was no evidence the GHMRP had sufficient trash cans available to store garbage between trash collection days. b. A small back porch paved area was observed at the rear exit from the basement. Further observation revealed the steps leading from the ground level down to the paved entrance area outside the basement. This pavement was observed to be broken away where the bottom step junctions with the paved area. There was no evidence the pavement was maintained in good repair. c. The large stone at the right corner of the front basement entrance to the GHMRP was observed to be broken and hanging loose. The railing which was previously attached to the broken stone was no longer secured and did not provide needed support to persons ascending and descending the the steps leading down to the basement. d. A cut off pipe, which was approximately 1 1/2" in diameter and 2 inches in height, was observed standing directly to the right of the bottom step leading from the basement to the ground level walkway at the front of the GHMRP. 2. Interior of the facility: a. Space was observed between the dining room window and the wall at the bottom left side. This permitted the entrance of air into the room from the outside of the building. b. The surface of the three lower shelves of the large cabinet located in the kitchen adjacent to the first floor bathroom were rough and not easily cleanable.	I 090 b c d a b	 The pavement will be repaired by 04-30-07 The railing was fixed on 03-30-07 Cut off pipe was removed on 03-30-07 The window was stabilized properly on 04-17-07 A replacement window was ordered and be placed by 04-30-07 The shelves will be smoothed and painting to completed by 04-30-07	 04-30-07 03-30-07 03-30-07 04-17-07 04-30-07 04-30-07	

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1 090	Continued From page 2 c. Cracked floor tiles were observed in several areas of the facility, however were most prominent in the kitchen, first floor sitting room, and the basement living area. d. The gasket on the interior of the oven door was missing from the right side of range door. e. A broken section was observed on the top and side of the food processor, Observation on March 28, 2007 revealed the food processor was used to prepare the modified textured diets. Interview with staff indicated the food processor was scheduled to be replaced. There was no evidence the food processor was maintained in good repair. f. The vinyl on the couch in the sitting room was observed to be peeling. room.	1 090 C d e f	Cracked tiles will be replace by Sears maintenance will replace the gasket on 04-19-07. A new food processor was purchased on 04-18-07. Since the furniture is sturdy, DCHC will repair the cushions (new vinyl covers, cushion made) by	04-30-07 04-19-07 04-18-07 05-30-07
1 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff, and... This Statute is not met as evidenced by: On March 29, 2007, at 5:05 PM, review of the current Organizational Chart (not dated) kept in the Policies and Procedures Manual revealed the following: 1. The chart was not reflective of the numbers or categories of nursing staff. Review of personnel records earlier that day had indicated that some nurses were agency employees while others were consultants. The Director of Nursing	1 186	The chart was revised to reflect DCHC employees & contract employees. <i>Attachmet J'</i>	04-17-07

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I 186	Continued From page 3 confirmed this during the Exit Conference, at approximately 6:15 PM; 2. The chart was not reflective of the numbers of direct care staff; and, 3. Although the chart indicated that a Behavior Specialist was employed, interview with the Qualified Mental Retardation Professional and the Director of Nursing revealed that the clients residing in the facility did not use a Behavior Specialist; they received services solely from a licensed Psychologist for their behavior intervention needs. 4. The Qualified Mental Retardation Professional and Director of Nursing further indicated that the Organizational Chart presented was a generalized flow chart that applied to all facilities operated by the agency, and therefore did not apply specifically to this ICF/MR.	I 186	The number of direct care staff is reflected in the staffing schedule. Please See attachment - 'k' Please see the revised organization chart. Please see the revised organization chart.	4-18-07 4-17-07 4-17-07
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: 1. The facility failed to ensure that Resident #1's record accurately documented the status of the guardianship/ conservator services that were established for protecting his rights. D.C. Law 2-137, Section 7-1305.12 (formerly 6-1972) "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall	I 292		

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I 292	Continued From page 4 include: (1) Identification data, including the customer's legal status" On March 27, 2007, at 8:37 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #1 had a court-appointed guardian. The guardian was interviewed by telephone on March 28, 2007, beginning at 1:52 PM. She confirmed that she was his guardian. Review of Resident #1's records, beginning at 3:00 PM on March 28, 2007, revealed the following: 1. Resident #1's records did not contain the court papers from the date that a judge first appointed his cousin to serve as his guardian. 2. There were no court papers, past or recent, in the record that defined the role and responsibilities assigned to the guardian. 3. Resident #1's records did not contain court papers from the date that a judge first appointed a conservator. There were no court papers, past or recent, in the record that defined the role and responsibilities assigned to the conservator. 4. Resident #1's Individual Support Plan (ISP), dated 5/5/06, did not document the date that the cousin was appointed as guardian or define her role and responsibilities. 5. The ISP indicated that Resident #1 had a "conservator" appointed. The ISP did not, however, indicate the date when the conservator was appointed, or define his role or responsibilities. 6. Resident #1's Individual Financial Plan (IFP),	I 292	Client # 1 had a court hearing on 04-10-07, where the judge has ordered the attorney to submit a status report on client # 1's inheritance if any to the court by 04-30-07. DCHC will make sure that the new report be a part of his record. This court order is also as result of the conservator's lack of involvement in client # 1's affairs. <i>Attachment # L 1 to 2</i> Guardianship, papers were misfiled, we secured a copy and field in the Active Medical record as of 04/16/07. 1. (See Attachment). A 1 to A 7 2. 3. Conservatorship papers are now field in the Active Medical record as of 04-16-07 (See attachment) B 1 to B 4 4. Future ISP's will reflect & The appointment of guardians and 5. conservator. Since DCHC is in the process of preparing 2007 ISP for client # 1.	04-30-07

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I 292	Continued From page 5 dated 5/5/06, did not reflect the existence of a court-appointed guardian or define her role or involvement in the client's financial decision-making process. The IFP also did not reflect the existence of a court-appointed conservator or define his role or involvement in the client's financial decision-making process. 7. The QMRP was interviewed again on March 29, 2007, beginning at 8:30 AM. He examined the client's record and acknowledged that there were no court documents regarding the guardian or conservator. The interview also revealed that the QMRP, who had primary responsibility in preparing the client's annual ISP, was unsure of the roles and responsibilities of the guardian and conservator, as follows: a. He said he thought the cousin might have "limited medical" guardianship. While being interviewed, the QMRP looked through the group home office for documentation that would define the guardian's role and responsibility. At 9:05 AM, the QMRP presented court documents that indicated the cousin was appointed as "general guardian," effective 3/13/03. b. At 9:09 AM, the QMRP presented a document prepared by the conservator, dated March 2004, that was submitted to the court. The document did not clearly state the role and responsibility assigned by the court. The QMRP said the conservator had ceased contacting the resident and the group home a few years earlier because the resident had no assets. The appointment reportedly was based on the need to handle the sale of a relative's home. To his knowledge, the home had never been sold; therefore the resident remained without assets. The home reportedly was in disrepair and possibly slated for	I 292	6. Since DCHC is in the process of client # 1's 2007 ISP & IFP. The amendment will be included when ISP's are finalized. 7. DCHC assures that all court documents. Regarding conservators and guardians will be field in the current Active medical recorded as of 04-16-07. a + b QMRP was given an In-service on record keeping on 04-16-07. "c" Client # 1 had a court hearing on 04-10-07, where the judge has ordered the attorney to submit a status report on client # 1's inheritance if any to the court by 04-30-07. DCHC will make sure that the new report be a part of his record. This court order is also as result of the conservator's lack of involvement in client # 1's affairs.	5/15/07 4/16/07 4/16/07 4/30/07

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1292	<p>Continued From page 6</p> <p>demolition. The resident's record did not contain any documentation needed to verify the information being presented through interview.</p> <p>c. The QMRP stated that he had discussed the issue (sale of the family home) with the guardian; however, he acknowledged that those conversations had not been documented in the resident's record.</p> <p>d. The QMRP acknowledged that he had not called the conservator in recent years. He further indicated that the conservator's role and responsibility had not been discussed by the resident's interdisciplinary team.</p> <p>e. The QMRP was of the understanding that Resident #1's guardian was submitting semi-annual status reports to the court. Filing 6-month reports reportedly was mandated by the court. There were no status reports, however, available for review in the resident's record. The QMRP said he would need to follow-up with the guardian to confirm that she had been filing reports, as mandated and to request that the resident receive copies for inclusion in his record.</p> <p>2. The facility failed to update Resident #4's medical record to reflect the status of pathology report for the foreign body found in Client #4's stomach which was requested from the hospital.</p> <p>D.C. Law 2-137, Section 7-1305.12 (formerly 6-1972) "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (5) A record of each physical examination which</p>	<p>1292</p> <p>c + d</p> <p>e.</p> <p>2.</p>	<p>QMRP will document all pertinent conversations in the client's Active Medical Record and as of 04-16-07</p> <p>All reports submitted to court by guardian will be field in the Active Medical Record as of 4-16-07.</p> <p><i>See attached, D1-D4</i></p> <p>DCHC has requested the pathology report from [REDACTED]. Since the report has not been received the details of the plastic object have not been updated in the client's record. (Please see attachment) E 2.</p> <p>- Pertinent telephone calls will be documented in the Active Medical record from 04-16-07 onwards.</p>	<p>04-16-07</p> <p>4-17-07</p>

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I 292	<p>Continued From page 7</p> <p>describes the results of the examination" (16) A record of any seizures, illnesses, treatments thereof, and immunizations."</p> <p>The facility failed to update Resident #4's medical record to reflect the status of a hospital pathology report.</p> <p>Review of incident reports on March 27, 2007, at 3:12 PM, revealed that a foreign body was surgically removed from Resident #4's stomach on January 8, 2007. On January 9, 2007, a group home nurse wrote the following progress note: "... Per PMD talk with medical team to <sic> Georgetown University Hospital a plastic piece was removed from the stomach and was sent to pathology..." On the hospital discharge summary, the hospital physician wrote the following: "Large foreign body in stomach." The hospital provided no additional descriptive information regarding the object that was removed. Review of the incident report, investigation report, primary care physician's notes, nursing notes and other aspects of Resident #4's record failed to indicate the nature of the plastic object (size, color, etc.).</p> <p>When interviewed on March 28, 2007, at approximately 9:36 AM, the Qualified Mental Retardation Professional indicated that he was unaware of whether the nurses or primary care physician had requested the results of the hospital pathology lab investigation.</p> <p>Further review of Resident #4's record on March 29, 2007 failed to show evidence that the hospital pathology lab had sent the results of their evaluation of the object. In addition, the resident's nursing notes did not reflect follow-up with the hospital to obtain the results.</p>	I 292	<p>This deficiency was reviewed with the incident management investigator, and was asked to cover all areas of "how, when, where, what" question to complete a thorough investigation report. The incident management investigator Will continue to attend DDS incident management training as scheduled by DDS.</p>	<p>04-17-07 Ongoing</p> <p>04-17-07</p>

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I 292	Continued From page 8 Interview with the Director of Nursing (DoN) on March 29, 2007 indicated that a facility nurse had indeed telephoned the hospital sometime after the incident (date not specified). The DoN recalled the nurse having been told by the hospital that the plastic object had not been sent to pathology. However, the telephone call was not reflected in the resident's record.	I 292	Pertinent telephone calls will be documented in the Active Medical record from 04-16-07 onwards.	4-16-07
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: The morning medication administration pass was observed on March 27, 2007, beginning at 7:04 AM. At 7:20 AM, the Licensed Practical Nurse (LPN) was observed administering Resident #1's medications. The LPN left the facility shortly after 8:05 AM. According to Resident #1's March 2007 Medication Administration Record (MAR) and physician's orders (POs), the nurse was to have administered one tablet of Allegra D-24 Hour allergy medication. At no time was Resident #1 observed receiving Allegra D-24.	I 422		
I 479	3522.6(e) MEDICATIONS The record for a resident ' s prescribed controlled substances shall include the following: (e) Each time the controlled substance is to be taken or administered. This Statute is not met as evidenced by: The morning medication administration pass was	I 479		

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I 479	Continued From page 9 observed on March 27, 2007, beginning at 7:04 AM. At 7:20 AM, the Licensed Practical Nurse (LPN) was observed administering Resident #1's medications. The LPN left the facility shortly after 8:05 AM. According to Resident #1's March 2007 Medication Administration Record (MAR) and physician's orders (POs), the nurse was to have administered one tablet of Allegra D-24 Hour allergy medication. At no time was Resident #1 observed receiving Allegra D-24. Review of Resident #1's MAR on March 27, 2007, at approximately 10:45 AM, revealed that the medication nurse had mistakenly recorded having administered the Allegra D-24 on March 27, 2007.	I 479	The medication administration Nurse was in-serviced by DON & PMD on 04-03-07 The medication nurse was also reprimanded for the same. Staff was re-inserviced on 04-13-07 to follow diet orders- special diet protocols etc. <i>Attachment "G"</i>	04-03-07