

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2009
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NAME OF PROVIDER OR SUPPLIER CARLS PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NEWCOMB ST, SE WASHINGTON, DC 20032
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1000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted on February 18, 2009. A random sample of three residents was selected from a resident population of one woman and four men with various degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.</p>	1000		
1002	<p>3500.2 GENERAL PROVISIONS</p> <p>Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP licensee and its residence director failed to demonstrate that they understood that the provisions of D.C. Law 2-137, D.C. Code, Title 7, Chapter 13 (formerly Title 6, Chapter 19) governed the care and rights of the facility's 5 residents.</p> <p>The findings include:</p> <p>1. According to the Residence Director/House Manager (HM) and confirmed by review of Resident #1's records, he was admitted to the facility on September 20, 2008, with multiple, known diagnoses. There was no evidence that the GHMRP licensee and its HM understood the residents' right to receive prompt and adequate</p>	1002	<p><i>The facility has a Coordinator in place as of April 1, 09. Who will review chapter 35 and review past deficiencies, Training, personal records, meeting with HM, Charge Nurse and review all residents chart twice per month, and as needed.</i></p>	<p><i>4-1-09</i></p>

Health Regulation Administration <i>Taren Hutchison</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE CEO	(X6) DATE 4-13-09
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FORM APPROVED

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1002	<p>Continued From page 1</p> <p>medical attention and physical examinations upon admission, as follows:</p> <p>a. Cross-refer to 1325, 1326, 1327, 1330 and 1401. There was no evidence that a nurse had performed a full system physical evaluation of Resident #1 since his September 20, 2008 admission. At 3:26 PM, the HM also acknowledged that the resident had gone nearly 5 months before being evaluated by a primary care physician, on February 9, 2009.</p> <p>b. Cross-refer to 1390.2 Resident #1's records included a November 29, 2007 dental evaluation (report not signed) that reflected "inflamed gingiva, gingivitis" and decay in tooth #18 (as per chart). Resident #1's most recent Individual Support Plan (ISP), dated March 27, 2008, held a recommendation that he receive "comprehensive dental treatment ... scheduled 6 months." There was no evidence that he had been evaluated by a dentist since November 2007. At 3:27 PM, the HM acknowledged that Resident #1 had not been evaluated by a dentist since his September 2008 admission. She further indicated that he was without a designated dentist.</p> <p>2. Cross-refer to 1420. There was no evidence the GHMRP licensee and its residence director understood the residents' right to receive habilitation and training to enhance his/her ability to cope with his/her environment and "create a reasonable opportunity for progress toward the goal of independent living."</p> <p>According to the HM and Resident #1's record, he was admitted to the facility on September 20, 2008. His ISP, dated March 27, 2008, reflected only one training-related goal ("enroll in a day habilitation program"). At approximately 12:10</p>	1002	<p>2. Person # 1 team will meet and develop residential goals to intertwine with day program goals</p>	4-1-09

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1002	Continued From page 2 PM, interview with the Program Consultant revealed that his interdisciplinary team had not reconvened and there had been no new goals or objectives added to the resident's plan after he was admitted to the facility almost 5 months earlier. It should be noted that the resident was already enrolled in a day program at the time he came to the GHMRP and continued attending the program at the time of the survey.	1002	<i>New Goals are in place 4-1-09</i>	
1043	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 observation, interview and record review, the GHMRP failed to ensure that modified diets were reviewed at least quarterly by a dietitian. The findings include: On February 18, 2009, at 8:30 AM, Residents #1 and #2 were observed in the living room. Both individuals were of large, round stature and appeared to be overweight. The House Manager (HM), who arrived a few minutes later, stated that Resident #1 had been admitted to the facility in September 2008. 1. At 1:05 PM, review of Resident #1's most recent Nutrition Evaluation, dated November 29, 2007, revealed that he had weighed 265 lbs. at the time of the evaluation. The evaluation indicated a desirable weight range of 140 - 184 lbs. and "his weight is above the healthy weight range." The nutritionist (evaluation not signed)	1043		

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1043	Continued From page 4 not include any nursing reports from 2008 or 2009.	1043		
1062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that cleaned dishes were stored to maintain their sanitary condition. The finding includes: On February 18, 2009, at 4:59 PM, water was observed trapped in the bottoms of 3 white cereal bowls that were stacked in a kitchen cabinet. The House Manager indicated that the bowls were used on a daily basis. She further indicated that the bowls had been washed then placed in the cabinet before they had fully dried. As such, the water could not air dry, to ensure proper sanitation.	1062	Staff will be retrained on universal precaution and proper techniques for hand washing and dish washing including how to store cups and bowls	4-1-09
1062	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip all bathrooms used by residents	1062		

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1082	<p>Continued From page 5</p> <p>with paper towels and paper cups.</p> <p>The findings include:</p> <p>1. On February 18, 2009, at 9:28 AM, the restroom located in Resident #4's bedroom area was without paper towels and there was no evidence of a paper towel dispenser. In addition, the paper cup dispenser was empty. At 9:30 AM, interview with the House Manager revealed that staff did not place paper towels and paper cups in the bathroom because Resident #4 had stuffed them in the toilet at times in the past. When asked if a psychologist had evaluated this alleged behavior, the House Manager acknowledged that the facility was unsure of which resident had stuffed them in the toilet.</p> <p>2. At 4:43 PM, there was no hand soap available for use in the bathroom located on the 2nd floor.</p> <p>3. At 4:51 PM, the paper cup dispenser in the bathroom located adjacent to the first floor living room was empty.</p>	1082	<p><i>The facility's Support Coordinator and H M + Charge Nurse will. Review employees job description on keeping stock in bathrooms as well as keeping caustic in a locked area.</i></p>	4-1-09
1095	<p>8504.6 HOUSEKEEPING</p> <p>Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each resident.</p> <p>The finding includes:</p>	1095	<p><i>All caustic are locked in closet. Staff was informed to lock all caustic away.</i></p>	4-1-09

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I 095	Continued From page 6 On February 18, 2009, at 4:50 PM, bottles of Spic n Span, Pine Glo, Mr. Clean and other poisonous agents were observed being stored openly on the top shelf in the coat closet located near the main floor bathroom. At that moment, a direct support staff person walked past and informed the House Manager that the cleaning agents were placed there for use by the overnight staff.	I 095	<i>A training has been set for 4-17-09. The agenda will be on TSP and the most inaugurated setting. The agenda/sign in sheet can be sent once the class has taken place.</i>	4-17-09
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the House Manager (HM) on February 18, 2009 at 9:34 AM revealed the facility had five shifts of direct care personnel. The shifts were weekdays 8 AM - 4 PM, 4 PM - 12 AM, 12 AM- 8 AM and on weekends 9 AM - 9 PM and 9 PM - 9 AM. Review of the fire drill log book from February 2008 to February 2009, revealed that the facility failed to hold fire evacuation drills quarterly on all shifts in the first, second, third and fourth quarters. Review of the fire drill log book February 2008 to February 2009, revealed that the facility failed to hold fire evacuation drills from March 2008 to May 2008 and September 2008 to November	I 135		

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I 135	Continued From page 7 2008 for the 8 AM - 4 PM morning weekday shift. Additional review of the records revealed that there were no fire drills conducted from June 2008 to August 2008 during the 12 AM - 8 AM overnight shifts during the week. Further interview the HM acknowledged that fire drills were not conducted quarterly on each shift. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	I 135		
I 165	<p>3507.4(c) POLICIES AND PROCEDURES</p> <p>The manual shall incorporate policies and procedures for at least the following:</p> <p>(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident;</p> <p>This Statute is not met as evidenced by: Based on the review of the GHMRP's policies and procedures, the GHMRP failed to provide evidence of policies for the destruction of medications.</p> <p>The finding includes:</p> <p>On February 18, 2009, at approximately 10:56 AM, review of the policies and procedures revealed no evidence of a policy on destroying medications. At approximately 1:30 PM, the facility's Registered Nurse (RN) confirmed that she had not developed a policy on destroying medications.</p> <p>At approximately 5:10 PM, an expired tube of a prescribed medication was observed in the drawer of Resident #4's bedroom nightstand.</p>	I 165	<p><i>All Nurses were informed that all creams etc /meds are to be locked in med closet. They were also told (reminded) they are paid to do all meds + treatments charting notes etc. The policies for destroying medication are in the MTR book and has been there for years. The Charge nurse was informed of this. She also wrote a up to date</i></p>	<p><i>2-28-09</i></p> <p><i>3-26-09</i></p>

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I 165	<p>Continued From page 8</p> <p>The label on the tube of Mometasone Furoate Cream USP, 0.1% indicated an expiration date of February 22, 2008 (one year earlier). The House Manager, who was present during the walk-through, stated that Resident #4 was to apply it to his face in the morning. The tube, however, remained approximately 98% full. The HM further indicated that staff were expected to remind the resident to apply it. She acknowledged that she had not verified whether he had been using the cream as prescribed. She removed the tube from the drawer and said she planned to discard it.</p> <p>It should be noted that at 5:17 PM, the RN said that all tubes of prescribed topical medications should be stored in the locked medication closet. She unlocked the medication closet, looked through the baskets and other supplies for a current tube of Mometasone Furoate Cream USP, 0.1% then stated "I don't see it." The RN then presented the resident's February 2008 Medication Administration Record (MAR). The MAR indicated that the cream should be applied "at bedtime." Further review of the MAR revealed that the evening LPN had already initialed it for that night (February 18, 2009), even though there was no tube of (unexpired) Mometasone Furoate Cream on hand. The LPN's initials were present on the MAR for every previous day in February 2009. When asked about the cream, the RN could not verify that Resident #4 had received staff reminders as needed (as per the HM). In addition, she acknowledged that she had not inventoried medications and/or determined whether his Mometasone Furoate Cream was kept available for use daily.</p>	I 165	<p><i>"Continued from,"</i> <i>page 7</i></p> <p><i>" "</i></p> <p><i>2-25-09</i></p> <p><i>All meds will be reviewed by the Charge Nurse to make sure that all med cream topical are current and in stock or R/c</i></p> <p><i>The LPN was counseled 2-25-09 on signing off on meds or cream he did not administer and to check for expired orders. Will ask PCP if cream can be applied in the AM Not bedtime</i></p>	
I 180	3508.1 ADMINISTRATIVE SUPPORT	I 180		

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I 180	<p>Continued From page 9</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide adequate administrative support to ensure that residents' needs were met.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross-refer to I043. The February 18, 2009 survey findings revealed that none of the residents with specialized diets were receiving professional nutrition services. 2. Cross-refer to I390.2. The February 18, 2009 survey findings revealed that Resident #1 had been without a designated dentist since he was admitted to the GHMRP on September 20, 2008. 3. Cross-refer to I401, I470 and I471. There was no evidence that the Registered Nurse provided assessment services and administrative oversight as defined in her job description. The RN reported having been hired in July 2008. There was no evidence, however, that any of the health-related deficient practices outlined in this report had been identified by the facility prior to the survey. 	I 180		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p>	I 206	<p><i>All staff was informed that health care are required by DPH as well as Carls Place inc, in order to maintain employment</i></p>	

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I 206	Continued From page 10 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the House Manager and review of the personnel records on February 18, 2009, beginning at 11:29 AM, revealed the following: 1. The GHMRP failed to provide evidence that current health certificates were on file for two of the six direct care staff (Staffs #3 and #6). 2. The GHMRP failed to provide evidence that current health certificates were on file for two LPNs (Consultants #1 and #3).	1206	The Support Coordinator + HM will review personal records to keep files up dated. Support Coordinator to start 4-1-09. HM will start review as of 2-28-09, when the record were checked by HM it was reported that all employees were current with health cert.	2-28-09
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and review of staff in-service training records and personnel files, the GHMRP failed to provide ongoing in-service training to ensure that staff and nurse consultants maintained their current cardiopulmonary resuscitation (CPR) certifications and First Aid	1222	The Support Coordinator and HM will monitor CPR; 1ST Aids Status on all employees. Also all employees have been informed that they must have cards in order to work	2-28-09

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I 222	<p>Continued From page 11 training.</p> <p>The findings include:</p> <p>On February 18, 2009, at approximately 10:03 AM, the House Manager (HM) was asked about which staff had current CPR certifications. The HM stated that there were some employees whose certifications had expired. At the time, there were no new CPR/First Aid training courses scheduled; however, she expressed interest in making such arrangements. Further interview revealed that the facility placed photocopies of the CPR certification cards in each employee's personnel file. Beginning at 11:31 AM, review of the personnel files revealed the following:</p> <ol style="list-style-type: none"> 1. There was no evidence that two of the six direct care staff (Staffs #2 and #5) had current CPR certifications. 2. There was no documented evidence that the Registered Nurse had current CPR certification. 3. There was no evidence of current First Aid training for two of the six direct care staff (Staffs #2 and #5). 4. There was no evidence of current First Aid training for two LPNs (Consultants #2 and #3). <p>It should be noted that Staff #2 was assigned to work the overnight shift alone. At approximately 8:30 AM, Staff #2 indicated that she had worked in the GHMRP for "about one year." There was no indication of past CPR certifications or First Aid training documented in her personnel record.</p> <p>Similarly, Staff #5 was scheduled to work alone from 9:00 AM - 9:00 PM on Saturdays and</p>	1222	<p>Continued from page 11</p> <p>Continued from page 11</p> <p>Continued from page 11</p>	<p>2-28-09</p> <p>2-28-09</p> <p>2-28-09</p>

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1222	Continued From page 12 Sundays. Her personnel file also did not reflect any past CPR or First Aid training.	1222	Continued from page 11	2-28-09
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1223	<p>3510.4 STAFF TRAINING</p> <p>Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on interview and review of staff training records and personnel records, the GHMRP failed to make available agendas and signature sheets to document staff in-service training.</p> <p>The finding includes:</p> <p>On February 18, 2009, the House Manager was interviewed in the GHMRP, beginning at 8:55 AM. She indicated that she had worked "with youth" for the 14 years prior to her employment with Carl's Place, which began in June 2008. At approximately 9:57 AM, she stated that she had received training regarding the Chapter 35 regulations that govern the operation of group homes for persons with mental retardation and related disabilities at the time of hire. At approximately 10:25 AM, however, review of her personnel file and staff in-service training records revealed no documented evidence of said training.</p>	1223	<p>There are sign in sheet for the training that was done. However a New agenda and training list is being developed and will start 4-17-09</p>	4-17-09
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1231	<p>3510.5(h) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(h) Orientation programs for each new employee which shall include philosophy, organization,</p>	1231	<p>The sign job description and orientation sheet from last year are in the employees folder. However new sheet have been signed</p>	3-6-09
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1231	Continued From page 13 programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and... This Statute is not met as evidenced by: Based on interview and review of staff training records and personnel records, the GHMRP failed to include orientation programs for new employees that included a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care of its residents. The findings include: On February 18, 2009, at 3:37 PM, interview with the Registered Nurse revealed that she had not received training on D.C. Law 2-137 or the Chapter 35 regulations applicable to this GHMRP. At approximately 10:26 AM, review of her personnel file and the staff in-service training records revealed no evidence that she had received training on those statutes/regulations since she began employment with the facility in July 2008.	1231	<i>Continued from page 12</i> <i>1231</i>	<i>3-6-09</i>
1272	3513.1(c) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (c) Weekly staff schedules, including substitutions; This Statute is not met as evidenced by: Based on interview and record review, the facility	1272		

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1272	Continued From page 14 failed to maintain a weekly staff schedule, to reflect current employees and substitutions. The finding includes: On February 18, 2009, the facility failed to provide evidence of a weekly staff schedule. When asked about a staff schedule at approximately 10:02 AM, the House Manager stated that they had one on their computer; however, their printer had "just died." She was, therefore, unable to print one.	1272		
1325	3517.6(a) ADMISSION POLICIES PROCEDURES Each resident, prior to admission if possible or within ten (10) days of admission shall receive a health inventory, screening and immunizations which may include the following and any other tests as determined appropriate by the examining physician: (a) A complete medical history including vaccination history, immune status and any condition that may predispose the resident to acquiring or transmitting infectious diseases; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that prior to admission or within ten days of admission, Resident #1 received a health inventory, screening and immunizations... that included the following: (a) a complete medical history including vaccination history, immune status... The finding includes:	1325	<i>it was not possible to obtain prior immunization. The Case Manager came with what she had from the Aunt who the resident lives with due to his mothers illness.</i>	2/18/09

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1325 Continued From page 15
On February 18, 2009, at approximately 8:40 AM, the House Manager stated that Resident #1 had been admitted to the GHMRP in September 2008. The resident's records were reviewed later that day, beginning at 12:02 PM. His Individual Support Plan (ISP), dated March 27, 2008 contained a Physical Examination report dated July 27, 2007. Another, more recent Medical Evaluation, dated February 9, 2009 was filed elsewhere in his record. Neither of the two evaluations provided Resident #1's vaccination history or immune status, and there were no other documents observed in his records that provided this information. The resident's record reflected an admission date of September 20, 2008. At 3:26 PM, interview with the House Manager and Registered Nurse confirmed that the resident had not received a health inventory during his first 4+ months in the facility. They also confirmed that his record did not reflect an immunization or vaccination history.

1325

When new individuals 3-28-09 are admitted they should have a current physical and copies of vaccination/PPD etc. This must have been an oversight. In the future a physical will be done within 10 days. This will be monitored by the Charge Nurse + H M and other nursing staff and Case manager and Nutrition Consultant. All medical and other needs will be addressed by the team before and after admission.
Continued from 1325 3-28-09

1326 3517.6(b) ADMISSION POLICIES PROCEDURES
Each resident, prior to admission if possible or within ten (10) days of admission shall receive a health inventory, screening and immunizations which may include the following and any other tests as determined appropriate by the examining physician:

(b) Determination of the Hepatitis B antigen and antibody status of each resident to acquiring or transmitting infectious diseases;

This Statute is not met as evidenced by:
Based on interview and record review, the GHMRP failed to ensure that prior to admission or within ten days of admission, each resident

1326

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I 326	Continued From page 16 received a health inventory, screening and immunizations including a determiniatin of their Hepatitis B antigen and antibody status, for one of the four residents included in the sample. (Resident #1) The finding includes: Cross-refer to I325. Resident #1 did not receive a complete health inventory until more than 4 months had passed after his admission. Review of the resident's July 27, 2007 and February 9, 2009 medical evaluations revealed no evidence that the resident's Hepatitis B status had been assessed. At 3:26 PM, interview with the House Manager and Registered Nurse confirmed that the resident's Hepatitis B status had not been assessed.	I 326	<i>Continued from 1325 " page 15</i>	<i>4-30-09 " 3-28-09</i>
I 327	3517.6(c) ADMISSION POLICIES PROCEDURES Each resident, prior to admission if possible or within ten (10) days of admission shall receive a health inventory, screening and immunizations which may include the following and any other tests as determined appropriate by the examining physician: (c) Tuberculosis screening; and... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that prior to admission or within ten days of admission, each resident received a health inventory, screening and immunizations including Tuberculosis screening, for one of the four residents included in the sample. (Resident #1)	I 327	<i>Continued from 1325 page 15</i>	<i>4-30-09 3-28-09</i>

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I 327	Continued From page 17 The finding includes: Cross-refer to I325. Resident #1's record documented that he began residing in the GHMRP on September 20, 2008. At the time of admission, his record did not reflect a recent (within 12 months) PPD/tuberculin test. At 3:26 PM, interview with the House Manager and RN confirmed that more than 4 months passed before a physician performed a tuberculosis screening, on February 9, 2009. [Note: On February 11, 2009, a facility nurse documented a "negative" reading in the resident's record.]	I 327	<i>Continued from 1325</i>	3-28-09
I 330	3517.8 ADMISSION POLICIES PROCEDURES Each GHMRP shall secure a physician's written report of the health inventory, which shall provide sufficient information concerning the resident's health including treatment, special diet, or medication orders to enable the GHMRP to provide appropriate services. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to secure a physician's written report of a health inventory that provided sufficient information concerning Resident #1's health needs. The findings include: On February 18, 2009, at 8:30 AM, Resident #1 was observed in the living room. He appeared to be overweight. At 10:05 AM, interview with the House Manager (HM) revealed that Resident #1 had recently started taking Seroquel, after having been assessed by a psychiatrist. The HM also stated that the resident had received a physical evaluation on February 9, 2009. A moment later,	I 330	<i>The Charge Nurse, support Coordinator and HM will over see these areas such as Physical, Health Passport, PPD etc. There will be a tracking sheet put in place to keep up with Physical, ISP BSP ^{KA} Nutrition etc.</i>	4-15-09

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I 330	Continued From page 18 review of the resident's medical records revealed the following: 1. Review of the resident's Health Passport and Individual Support Plan (ISP), dated March 27, 2008, revealed that his known diagnoses included: obesity, seizure disorder, allergic rhinitis, left hemi-paresis, agenesis of corpus callosum and schizophrenia. A consultation form found elsewhere in his medical chart documented that on January 23, 2009, a psychiatrist diagnosed "poor impulse control" and prescribed Seroquel 200 mg twice daily "for agitation." Review of the February 9, 2009 physical evaluation, however, revealed that it failed to reflect any Axis I diagnosis (either schizophrenia or poor impulse control). 2. The February 9, 2009 physical evaluation failed to include the newly-prescribed Seroquel in the listing of current medications. 3. The February 9, 2009 physical evaluation failed to reflect his diagnosis of allergic rhinitis, diagnosed in the past. 4. A consultation form in his medical record indicated that on December 2, 2008, a neurologist determined that Resident #1 was allergic to the medication "Topamax (causes hallucinations)." Review of the February 9, 2009 physical evaluation, however, revealed that the physician had placed a check mark indicating "None" for known "Allergies/Drug or Food." 5. In addition, the physician had left blank the space on the February 9, 2009 physical evaluation designated for recording the resident's weight. The physician had, however, written "obese" under the resident's General	I 330	The Charge Nurse / Support Coordinator and HM will all work on review of the Health Passport, ISP and current diagnosis. A re-eval will be done in order to clear up the diagnosis of allergic to what Meds. Also they will review physician evaluations in order to make sure there are no blanks and other mistakes on evaluation. The charge nurse will head this with SC and HM rechecking so nothing will be overlooked	4-30-09

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1330	<p>Continued From page 19</p> <p>Appearance. There was no evidence that the resident was weighed by his physician during the physical evaluation. Further review of the resident's medical chart also failed to show evidence that he had been weighed by a nurse or other facility staff since he was admitted more than 4 months earlier.</p> <p>At approximately 3:30 PM, the HM and RN were asked about the February 9, 2009 physical evaluation and how the GHMRP had facilitated the process. The HM said she had forwarded Resident #1's Health Passport via facsimile to the physician's office prior to the February 9, 2009 evaluation, as per the physician's request. The RN indicated that she had not been involved in the process. Further interview revealed that the HM had not sent other medical records to the physician. A second review of Resident #1's Health Passport revealed that the RN had updated it on February 8, 2009. However, the Health Passport did not reflect the most recent clinical findings, such as the December 2, 2008 neurological evaluation and the January 23, 2009 psychiatric evaluation.</p>	1330	<p><i>Continued from page 19</i></p> <p><i>1330</i></p>	4-30-09
1372	<p>3519.3 EMERGENCIES</p> <p>Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident ' s physician, and the agency ' s on-duty administrator.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty</p>	1372		

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1372	Continued From page 20 administrator. The finding includes: On February 18, 2009, at approximately 5:03 PM, there was no list of emergency contact numbers posted near the telephone located at the staff desk in the foyer. The House Manager, who was present during the environmental walk-through, acknowledged that there was no list posted. She stated that in the past, they had posted a list. However, the list included her phone number and that of the agency's administrator. One of the residents reportedly called their telephone numbers repeatedly, so they had removed the list in response. This is a repeat deficiency. ***** Previously, the November 1, 2007 licensure deficiency report included the following: On November 1, 2007, the GHMRP did not have posted near the telephone, emergency numbers, to include <u>fire and rescue squads, the local police department, the resident's primary care physician</u> <u>nor the on-duty administrator.</u>	1372	<i>All emergency numbers are posted at Staff work station and Staff office.</i>	
1390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current "Outcome Performance Measures" from the "Council on Quality and Leadership in Support for People With Disabilities" (Council) and to the	1390	<i>We have asked the case manager for several months for BSP. The BSP is a Community Based waiver Service and a referral can only come through DDS. However we had</i>	

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I 390	<p>Continued From page 21</p> <p>extent of funds appropriated for purposes of D.C. Law 2-137, as amended.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure residents received professional services in accordance to their needs as identified in the Individual Support Plan, for one of the three residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure Resident #1 received timely evaluation by a psychologist and/or development of a behavior support plan, as follows:</p> <p>On February 18, 2009, at approximately 10:05 AM interview with the House Manager revealed that Resident #1 had been assessed recently by a psychiatrist, who prescribed Seroquel "for agitation." The resident's current medication regimen also included Risperdal.</p> <p>Beginning at 12:05 PM, review of Resident #1's Individual Support Plan (ISP), dated March 27, 2008, revealed that he was living with family at the time. He was prescribed Zoloft for the treatment of depression. He had also been diagnosed with undifferentiated schizophrenia in 2005 for which he was prescribed Geodon. In a Psychological Assessment dated November 29, 2007, a psychologist had recommended that he receive "an updated psychological assessment within one year." The ISP included the following: "<resident's name> is not currently working with a behavior support plan, although there is a history of behavioral concerns including tantrums, low frustration tolerance and property destruction."</p>	I 390	<p>contacted the waiver provider direct and we are working to get paper work done. This process is still on going as of 4-9-09. The case manager is also working with the provider to speed the process up. We don't know if 4-18 is a good date. Continued from page 21</p>	5-5-09 ?
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I 390	<p>Continued From page 22</p> <p>The resident's case manager was to "submit a referral for crisis prevention through the Home and Community Based Waiver."</p> <p>At approximately 2:00 PM, further review of Resident #1's record revealed that he was not re-assessed by a psychologist within one year of the November 2007 assessment. An authorization letter from Medicaid, dated May 20, 2008, identified a provider by name for "Diagnostic Assessment to determine the need for behavioral, preventive, consultative or follow-up services" however, he was not assessed until December 29, 2008, which was 3 months after his September 20, 2008 admission to the facility. The psychologist recommended development of a behavior support plan (BSP) as Resident #1 was taking psychotropic medications to manage behaviors. To date, however, the resident remained without a BSP.</p> <p>2. The GHMRP failed to ensure timely dental evaluation and treatment, as follows:</p> <p>On February 18, 2009, beginning at 12:05 PM, review of Resident #1's ISP, dated March 27, 2008, revealed that he had received a dental evaluation on November 29, 2007. The dentist found gingivitis and decay in Tooth #18. The ISP included the recommendation that he receive "comprehensive dental treatment... including preventive care scheduled every 6 months..." The resident's record, however, failed to show evidence of any dental visits or treatments since November 2007. At 3:28 PM, interview with the House Manager and Registered Nurse confirmed that the resident had not been seen by a dentist. The House Manager stated that she had "to find him a dentist," as the dentist serving the other 4 residents reportedly was "not accepting new</p>	1390	<p><i>Continued from page 21 and 22</i></p> <p><i>Continued from page 21 and 22</i></p> <p><i>Dental Appointment done</i></p>	<p>5-1-09</p> <p>u</p> <p>3-27-09 and 4-3-09</p>	

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1390 Continued From page 23

Medicaid" patients. The RN indicated that to date, she had not been involved in the process.

It should be noted that Resident #1 was admitted to the GHMRP on September 20, 2008, more than 4 months before the survey.

It should be further noted that the facility's "Policies and Procedures on Securing Medical and Dental Care" included the following: "Recommendations for general care, specialty care, and medical follow-up will be carried out by the <facility's> nurse within the time frame prescribed by the ... specialist... Preventive dental care consisting of at least two annual visits and tactile evaluations... A treatment plan is to be generated that outlines specific dental needs... The Nurse will... conduct periodic audits in tracking appointments, timeliness of service, follow-up visits, consistency, treatment delivery and documentation of data pertaining to... key elements that impact the person's habilitation as specified in the ISP" and "quality service delivery in medical and dental components through treatment plans."

1390

The Nurse was informed of her duties of medical follow up and tracking. The Support Coordinator will also check behind the nurse so follow up will not be overlooked. The treatment plan will come from the dental office and the nurse will follow up on the dental plan.

4-1-09

1392 3520.2(b) 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:

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1392	Continued From page 24 (b) Dentistry. This Statute is not met as evidenced by Based on record review and interview, the GHMRP failed to ensure access to a dentist and to dental evaluations and treatment as deemed necessary by the interdisciplinary team, for one of the three residents in the sample. (Resident #1) The finding includes: Cross-refer to 1390.2. On February 18, 2009, at approximately 8:40 AM, interview with the House Manager revealed that Resident #1 was admitted to the facility on September 20, 2008. Review of Resident #1's records confirmed the admission date. The record also revealed no evidence that he had been referred to a dentist since he came to this GHMRP. At 3:29 PM, further interview with the House Manager and Registered Nurse confirmed that the resident had not received dental services since November 2007. In addition, they indicated that to date, no dentist had been identified to provide Resident #1's care.	1392	Dental appointment scheduled	3-27-09
1394	3520.2(d) 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.	1394		

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1394	Continued From page 25 (d) Nutrition: This Statute is not met as evidenced by: Based on record review and interview, the GHMRP failed to ensure access to a nutritionist/dietitian as deemed necessary by the interdisciplinary team, for two of the three residents in the sample. (Residents #1 and #2) The findings include: Cross-refer to I043 On February 18, 2009, at 8:30 AM, Residents #1 and #2 were observed in the living room. Both individuals were of large, round stature and appeared to be overweight. The survey revealed, however, that neither resident had access to a licensed nutritionist/dietitian for evaluation and nutrition counseling. 1. On February 18, 2009, at approximately 8:40 AM, interview with the House Manager (HM) revealed that Resident #1 was admitted to the facility on September 20, 2008. Review of Resident #1's records later that day confirmed the admission date. At 1:05 PM, review of Resident #1's most recent Nutrition Evaluation, dated November 29, 2007, revealed that he had weighed 265 lbs at the time of the evaluation. The evaluation indicated a desirable weight range of 140 - 184 lbs. and "his weight is above the healthy weight range." The record also revealed no evidence that he had been assessed by a nutritionist/dietitian since he came to this GHMRP. 2. At 2:00 PM, review of Resident #2's most-recent Nutrition Evaluation, dated September 26, 2007, revealed that the resident	1394	Nutritionist has been contracted and assessments and training are scheduled	4-15-09

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1394	Continued From page 26 had a recommended 1800 calorie, low sodium and low fat diet. Further review failed to show evidence that the nutritionist/dietitian had reviewed Resident #2's diet on a quarterly basis. For example, the most recent nutrition review for Resident #2 was documented on February 16, 2008, a year prior to this survey. At approximately 3:30 PM, further interview with the HM and Registered Nurse confirmed that the GHMRP did not currently have a consultant agreement with a nutritionist/dietitian.	1394		
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide professional treatment services and services designed to prevent deterioration or further loss of function, for two of the three residents in the sample (Residents #1 and #2). The findings include: 1. The Registered Nurse (RN) failed to ensure that Resident #2's psychiatrist was made aware of the neurologist's recommendations as evidenced below: Review of Resident #2's physician orders (POS) dated January, 2009 on February 18, 2009 at	1401		

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I 401	Continued From page 27 approximately 1:00 PM revealed Resident #2 was prescribed Trileptal 600 mg twice a day for seizures. Review of the Neurologist consultant report dated May 5, 2008 at approximately 1:45 PM, revealed Resident #2 was seen at the Epilepsy Clinic for his initial clinic visit. The impressions/findings revealed the following: a. "I [Neurologist] agreed that it could be worthwhile to see if Resident #2 would do well in terms of his seizure control off the Trileptal. If the psychiatrist does not feel he needs to be on the Trileptal, they could taper off the Trileptal by 300 mg every week, so that after four weeks, he would be off Trileptal." Interview with the RN on February 18, 2009, at approximately 5:40 PM, revealed that she was unsure if follow-up had occurred with the psychiatrist. The RN stated that she would have to refer to the House Manager (HM) for further information. Review of the RN's job description earlier that day, at 11:29 AM, revealed one the following duties and responsibilities: " The staff nurse must be continually aware of the health of each individual and communicate concerns to the Primary Care Physician (PCP)." There was no evidence that Resident #2's PCP and/or psychiatrist were made aware of the neurologist's recommendations. b. "I [Neurologist] would like the GHRMP to get an EEG before they do the taper off of the Trileptal, as this can be informative in terms of recurrence risks." Interview with the GHMRP's RN on February 18, 2009, at approximately 5:41 PM, revealed that she was unsure if the psychiatrist was made aware of the recommendation for Resident #2 to have an EEG completed. The RN stated that the HM might have further information. There was no	I 401	The Nurse will be responsible for the Neurologist PCP receiving all relevant and current information. The Support Coordinator will also check behind the Nurse. The Charge Nurse RN will be responsible for all medical oversight of Residents	4-1-09

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1401	Continued From page 28 evidence that Resident #2's psychiatrist and/or PCP was aware of the neurologist's recommendation for an EEG c. "He [Resident #2] should be on 1200 to 1500 mg of calcium... and... 200 international units of vitamin D per day." Interview with the RN on February 18, 2009 at approximately 5:42 PM, revealed that she was unsure if the psychiatrist was made aware that Resident #2 should be prescribed 1200 to 1500 mg of calcium per day. The RN stated that the HM might have further information. There was no evidence that Resident #2's psychiatrist and/or PCP was aware of the neurologist's recommendation for calcium and Vitamin D supplements. d. "He [Resident #2] should have a DEXA-scan to check his bone density since he had been on Trileptal for decades." Interview with the RN on February 18, 2009 at approximately 5:44 PM, revealed that she was unsure if the psychiatrist was made aware of the recommendation for Resident #2 to have a DEXA-scan completed. Again, the RN referred this surveyor to the HM for further information. There was no evidence that Resident #2's psychiatrist and/or PCP were aware of the neurologist's recommendation for a bone density study. Interview with the HM on February 18, 2009, at approximately 6:40 PM, revealed that Resident #2 had not been seen by his psychiatrist since the May 21, 2008 neurology visit. Further interview with the HM revealed that the psychiatrist was not aware of the neurologist's aforementioned recommendations. The HM stated that Resident #2 was scheduled to see his psychiatrist on March 5, 2009.	1401	c. Nurse will assure PCP and psychiatrist are aware of neurologist recommendation for calcium d. Nurse will follow up with neurologist recommendation for bone density study.	4-1-09 5-1-09

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1401	<p>Continued From page 29</p> <p>2. Review of Resident #2's Physician's Orders (POs) on February 18, 2009 at approximately 2:20 PM, revealed the resident was prescribed Seroquel XR 200 mg for psychosis and Trileptal 600 mg for seizures. Further review of the POs revealed orders for Prolactin levels every three (3) months. Review of Resident #2's labs, at approximately 2:30 PM, revealed the only labs in the record were dated August 20, 2008. The labs did not address Prolactin levels. When interviewed at approximately 5:58 PM, the RN acknowledged that labs had not been done every three months as recommended.</p> <p>3. On February 18, 2009, beginning at 12:02 PM, review of Resident #1's records revealed no documented evidence that either the RN or an LPN had performed a physical assessment of the resident, since he was admitted to the GHMRP on September 20, 2008. At approximately 3:27 PM, the RN acknowledged that she had not assessed the resident. She further indicated that she did not know whether an LPN had assessed him. No additional information was presented before the survey ended at 6:40 PM that evening.</p> <p>4. On February 18, 2009, beginning at 12:02 PM, review of Resident #1's records revealed a pre-admission physical evaluation that he had received at a hospital clinic on July 27, 2007. The evaluation report was included in his March 27, 2008 Individual Support Plan (ISP), which was provided to the GHMRP at the time he was admitted on September 20, 2008. There was no documented evidence that his former PCP had performed a more recent physical assessment prior to his September 2008 admission. Resident #1's records reflected a February 9, 2009 physical evaluation; however, there was no evidence that this physician had seen the</p>	1401	<p><i>Continued from page 28</i></p>	
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I401	<p>Continued From page 30</p> <p>resident between September 20, 2008 and February 9, 2009. Beginning at 3:26 PM, interview with the RN and the HM confirmed that the resident had been without a PCP for over 4 months. The HM indicated that she had arranged for the February 9, 2009 physical in preparation for an upcoming ISP meeting. There was no evidence that the GHMRP obtained a current health inventory upon <u>Resident #1's admission</u>, as required in 22 DCMR 3517.6.</p> <p>5. Cross-refer to I390.2. The RN failed to ensure that Resident #1 received timely dental services (i.e. evaluation and treatment). The resident had been without a designated dentist since his September 20, 2008 date of admission. At 3:28 PM, interview with the RN and HM indicated that the nurse had not been engaged in the process of identifying a dentist who was willing to accept Resident #1 as a new patient.</p> <p>6. Cross-refer to I325, I326, I327 and I330. The RN had signed Resident #1's Health Passport on February 8, 2009. The Health Passport, however, failed to reflect the findings of his most recent professional consultations. For example, the resident had been seen by a neurologist on December 2, 2008. The neurologist's finding that the resident was allergic to Topamax was not reflected on the Health Passport or on the physical evaluation performed by his new PCP on February 9, 2009. Similarly, the resident had been evaluated by a psychiatrist on January 23, 2009, at which time he was diagnosed with "poor impulse control" and a new medication (Seroquel) was added to his regimen. The new diagnosis and medication were not reflected on the Health Passport or on the physical evaluation performed by his new PCP on February 9, 2009. At approximately 3:30 PM, the HM said she had</p>	I401	Continued from page 28	

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I 401	<p>Continued From page 31</p> <p>faxed Resident #1's health passport to the physician prior to the February 9, 2009 evaluation. She also stated that no other medical records had been forwarded to the PCP. The RN indicated that she had not been involved in the process.</p> <p>7. Cross-refer to I165. The only tube of Mometasone Furoate Cream USP 0.1% observed in the GHMRP on February 18, 2009 had a label indicating that it had expired 12 months earlier (February 22, 2008). The tube was approximately 98% full, with only two faint/minor indentations observed on its sides. The HM indicated that staff were expected to remind the resident to apply it. She acknowledged that she had not verified whether the resident had been using the cream as prescribed. At 5:17 PM, the RN said that all tubes of prescribed topical medications should be stored in the locked medication closet. She unlocked the medication closet, looked through the baskets and other supplies for a current tube of Mometasone Furoate Cream USP, 0.1% then stated "I don't see it." The RN then presented the resident's February 2008 Medication Administration Record (MAR). The MAR indicated that the cream should be applied "at bedtime." Further review of the MAR revealed that the evening LPN had already initialed it for that night (February 18, 2009), even though there was no tube of (current) Mometasone Furoate Cream found in the facility. The LPN's initials were present on the MAR for every previous day in February 2009. When asked about the cream, the RN could not verify that Resident #4 had received staff reminders as needed (as per the HM). In addition, she acknowledged that she had not inventoried medications and/or determined whether his Mometasone Furoate Cream was</p>	I 401	<i>Continued from page 28</i>	

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I 401	Continued From page 32 kept available for use daily. It should be noted that earlier that day, at approximately 1:30 PM, the RN had confirmed that the GHMRP was without a written policy on the destruction of expired medications. There was no evidence of RN oversight in accordance with her job description.	I 401	<i>Continued from page 28</i>	
I 412	3520.13 PROFESSION SERVICES: GENERAL PROVISIONS If a resident evidences the need for a professional service for which arrangements do not exist, the GHMRP shall have fourteen (14) days to show evidence of arrangements for provision of the professional service, except that in life threatening situations, arrangements must be made immediately. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to make arrangements with a dentist to ensure the provision of dental services for Resident #1. The finding includes: Cross-refer to I390.2. On February 18, 2009, at approximately 8:40 AM, interview with the House Manager (HM) revealed that Resident #1 was admitted to the facility on September 20, 2008. According to a November 29, 2007 dental assessment, the resident had gingivitis and decay in Tooth #18. The resident's March 27, 2008 Individual Support Plan recommended dental evaluation and treatment twice yearly. There was no documented evidence, however, that he had been referred to a dentist since he came to this GHMRP more than 4 months earlier. At 3:29 PM, further interview with the HM and Registered	I 412		

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1412	Continued From page 33 Nurse confirmed that he had been without and remained without a dentist	1412		
1420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning This Statute is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to ensure that the GHMRP provided habilitation and training to Resident #1 to enable him to acquire and maintain those life skills needed to cope more effectively with the demands of his environments and to achieve his optimum levels of physical, mental and social functioning The finding includes On February 18, 2009, at approximately 8:40 AM, the House Manager stated that Resident #1 had been admitted to the GHMRP in September 2008. The resident's records were reviewed later that day, beginning at 12:02 PM. His Individual Support Plan (ISP), dated March 27, 2008, had been developed prior to his admission to the GHMRP. The ISP did not include any training goals or objectives. At 2:04 PM, the facility's Program Consultant stated that there had been no interdisciplinary team meetings convened since Resident #1's September 20, 2008 admission, to determine what goals and objectives might be appropriate to meet his habilitation and training needs in the GHMRP. The Program Consultant acknowledged that the	1420	Person ISP is 3-27-09 new goals implemented after this meeting	3-30-09

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1420	Continued From page 34 resident remained without any formal training programs, outside of the habilitation day program that the resident attended on weekdays.	1420		
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by. Based on interview and record review, the GHMRP failed to ensure that each resident received training and assistance in accordance with the Individual Support Plan (ISP) recommendations for one of the three residents in the sample. (Resident #2) The finding includes: The facility failed to develop a self-medication program objective as identified in Resident #2's ISP. On February 18, 2009, at 2:32 PM, review of Resident #2's ISP, dated November 10, 2008, revealed a section called "Restoring Independence". Under this section, "it was suggested that a plan be put into place to help Resident #2 learn how to give himself medications." Interview with the GHRMP's Registered Nurse (RN), at approximately 5:55 PM, revealed that Resident #2 did not have a self-medication program	1422	Nurse will develop self medication plan for person #2	4-2-09
1455	3521.10(a) HABILITATION AND TRAINING Each GHMRP shall develop an activity schedule for each resident that includes the following	1455		

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I 455	Continued From page 35 unless contraindicated by the resident's Individual Habilitation Plan. (a) Structured activities including the weekends and holidays. This Statute is not met as evidenced by. Based on observation, interview and record review, the GHMRP failed to develop an activity schedule for one of the three residents in the sample (Resident #1) The finding includes: On February 18, 2009, at approximately 8:40 AM, the House Manager stated that Resident #1 had been admitted to the GHMRP in September 2008. The resident's records were reviewed later that day, beginning at 12:02 PM. His Individual Support Plan (ISP), dated March 27, 2008, had been developed prior to his admission to the GHMRP and therefore, did not include an activity schedule. Further review of the resident's records failed to show evidence of an activity schedule. At 12:05 PM, the facility's Program Consultant acknowledged that the GHMRP had not developed an activity schedule for Resident #1 to meet the requirements of 22 DCMR 3521.11. This is a repeat deficiency Previously, the December 8, 2006 licensure deficiency report included the following: On December 8, 2006, Resident #1 was home due to having a medical appointment. The client was observed in his room most of the day. He	I 455	-09 formal ited after this	3-30-09

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1455	Continued From page 36 came out to the living room area where the surveyor was. The staff was upstairs in another area of the facility. When asked what types of activities the Resident #1 participates in at the facility when he is not at his day placement, the QMRP had no answer to the question. When asked for the activity schedule, none was produced. It should be noted that this is a repeat deficiency from the December 2005 survey	1455		
1456	3521.11 HABILITATION AND TRAINING Each resident's activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on observation and record review, the GHMRP failed to establish an activity schedule and to make it available to direct care staff, for one of the three residents in the sample (Resident #1) The finding includes: Cross-refer to 1455. To date, there was no evidence that the GHMRP had developed an activity schedule for Resident #1 since his admission to the facility on September 20, 2008 This is a repeat deficiency Previously, the November 11, 2007 licensure deficiency report included the following:	1458	Person ISP is 3-27-09 formal schedule implemented after this meeting	3-30-09

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1458 Continued From page 37
There was no evidence that Resident #2 had an activity schedule. On November 1, 2007 at 8:40 AM, the resident was observed to leave the facility with a transportation driver. Interview with the resident on November 1, 2007 at approximately 4:30 PM indicated that she was going to the club this evening. Review of the community outing log revealed no evidence that the client attended the outing to the club.

1458

1470 3522.1 MEDICATIONS
Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq.
This Statute is not met as evidenced by:
Based on observation, interview, and record review, the GHMRP failed to ensure that licensed or trained staff administered medications, for five of the five resident of the facility. (Residents #1, #2, #3, #4 and #5)
The findings include:
1. On February 18, 2009, at approximately 2:30 PM, a man entered the facility, retrieved cups from a kitchen cabinet and interacted with the House Manager (HM) and the Registered Nurse (RN) in the living room. He stayed in the facility only a short while before departing, without introduction to the surveyors working in the dining room. At approximately 3:48 PM, when asked if the man seen earlier had been the evening Licensed Practical Nurse (LPN), the HM replied "Yes. He wrote in the book, but he didn't administer medications because the client's weren't home."

1470
Nurse ~~XXXXXX~~^{KL} was written up for the incident
Staff was informed that they are not to pass med and that this could be a police matter if they were found to be doing this. They were also informed that they would lose their jobs if the CEO/owner found this to be true.
The RN was talked to by the CEO

2-20-09
2-20-09

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1470	<p>Continued From page 38</p> <p>2. At 3:58 PM, review of Resident #1's January and February 2009 Medication Administration Records (MARs) revealed that:</p> <p>a. throughout the month of January 2009, the spaces for documenting administration of the evening dose of Depakote (1000 mg) had been left blank all 31 days;</p> <p>b. the space for documenting the morning medication administration (4 prescribed medications) had been left blank. [Note: The overnight staff had indicated earlier that morning that the nurse had already been to the facility and administered medications prior to the surveyors' arrival.]; and (3) the space for documenting the evening medication administration for that day had already been initialed by the evening LPN, even though the medications reportedly had not yet been administered.</p> <p>3. At 4:20 PM, interview with the HM and RN confirmed that the LPN had prepared the residents' medications and left them for the evening staff to administer later. They unlocked the medication storage closet and presented 5 separate cups with the residents' pre-poured medications. There was a separate tray marked for each resident, as labeled. Each tray also held a large plastic tumbler with water in it. The RN and HM explained that this was a routine practice. Every afternoon, the LPN poured the medications, initialed the MARs and left the GHMRP if the residents were not present. The RN acknowledged that this was not standard nursing practice, saying "Nurses didn't do this where I used to work <hospital and nursing home>... I'm learning how they do things in the group homes." Review of the RN's job</p>	<p>1470</p> <p>AM Nurse</p>	<p>concerning her duties and was told to read chapter 38 and take the class at DAS from the RN's training Dept.</p> <p>The AM Nurse was informed that she should sign off on all meals given. She was also informed that she is paid for 1 hour and not just a meal pass & leave.</p> <p>The Charge Nurse should have know this and wrote her up. The Charge Nurse was informed of her duties</p>	<p>2-26-09</p> <p>2-26-09</p> <p>2-26-09</p>

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1470	Continued From page 39 description earlier that day, at approximately 11:30 AM, revealed one of the following duties and responsibilities: "The staff nurse supervises and assists with medication administration." There was no evidence, however, that the RN had been supervising the medication administration process to ensure compliance with standard nursing practices. 4. At 5:10 PM, further interview with the HM revealed that she routinely administered medications to the residents before leaving the GHMRP at or around 6:00 PM. The HM acknowledged that she was neither a nurse or a Trained Medication Employee (TME). It should be noted that review of the GHRMP "Drug Administration" policy revealed that all drugs must be administered by licensed personnel.	1470	Continued from page 38		
1474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's nursing staff failed to accurately maintain residents' medication administration records (MARs), for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. Cross-refer to I470. On February 18, 2009, at 3:48 PM, when asked if the man seen earlier had been the evening Licensed Practical Nurse	1474			

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1474	<p>Continued From page 40</p> <p>(LPN), the Registered Nurse (RN) and House Manager (HM) indicated that the evening medication nurse/LPN had prepared medications, stored them in the medication closet and then left. The HM further stated that he "wrote in the book, but he didn't administer medications because the client's weren't home." At 3:58 PM, review of Resident #1's January and February 2009 Medication Administration Records (MARs) revealed that:</p> <p>a. throughout the month of January 2009, the spaces for documenting administration of Resident #1's evening dose of Depakote (1000 mg) had been left blank all 31 days;</p> <p>b. the space for documenting Resident #1's morning medication administration (4 prescribed medications) had been left blank. [Note: The overnight staff had indicated earlier that morning that the nurse had already been to the facility and administered medications prior to the surveyors' arrival.]; and,</p> <p>c. the space for documenting Resident #1's evening medication administration for that day had already been initialed by the evening LPN, even though the medications had not yet been administered.</p> <p>d. At 4:20 PM, further interview with the HM and RN confirmed that the LPN had prepared the residents' medications and left them for the evening staff to administer later. The RN and HM explained that this was a routine practice. Every afternoon, the LPN poured the medications, initialed the MARs and left the GHMRP if all of the residents were not present. According to the HM, she typically administered the medications shortly before she left the facility at approximately</p>	1474	<p><i>The Charge Nurse is to oversee MAR weekly and PRN</i></p> <p><i>" continued from " "</i></p> <p><i>page 40 1474</i></p> <p><i>cont from page 37</i></p> <p><i>1470</i></p> <p><i>The LPN should not be preparing med for staff to pass they are not med pass approved and can not do the. This is not a routine practice con on med pass</i></p>	<p><i>2-22-09</i></p> <p><i>2-20-09</i></p>
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1474	Continued From page 41 6:00 PM. e. At 4:26 PM, review of Resident #2's February 2009 MAR revealed the same deficient practices as described above. The LPN had initialed that evening's medications, even though they had not yet been administered. The morning nurse had not initialed any of Resident #2's medications earlier that morning (February 18, 2009). 2. Cross-refer to I165. At approximately 5:10 PM, an expired tube of a prescribed medication was observed in the drawer of Resident #4's bedroom nightstand. The label on the tube of Mometasone Furoate Cream USP, 0.1% indicated an expiration date of February 22, 2008 (one year earlier). At 5:17 PM, the RN unlocked the medication closet, looked for a current tube of Mometasone Furoate Cream USP, 0.1% then stated "I don't see it." The RN then presented the resident's February 2008 Medication Administration Record (MAR). The MAR indicated that the cream should be applied "at bedtime." Further review of the MAR revealed that: a. the evening LPN had already initialed it for that night (February 18, 2009), even though there was no tube of (unexpired) Mometasone Furoate Cream on hand; and, b. the LPN's initials were present on the MAR for every previous day in February 2009.	1474	<i>Review of the exit interview with the HM by the CEO revealed. The HM denied this practice. However she was written up never to do this if she had been.</i> <i>Continued from page 37, 1470</i> <i>Continued from page 37 1470</i>
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal	I 500	

Karen Kulkiser CE 4-13-09

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1500	<p>Continued From page 43</p> <p>been admitted to the GHMRP in September 2008. The resident's records were reviewed later that day, beginning at 12:02 PM. His individual Support Plan (ISP), dated March 27, 2008 contained a Physical Examination report dated July 27, 2007. Another, more recent Medical Evaluation, dated February 9, 2009 was filed elsewhere in his record. There was no evidence that the resident had received a complete physical by either a nurse or a physician during the 14 months between November 27, 2007 and February 9, 2009. In addition, interviews and record review revealed no evidence that a nurse or physician had performed a full system physical evaluation upon Resident #1's September 20, 2008 admission. The February 9, 2009 physical was performed more than 4 months after admission. It should be noted that the resident's record did not indicate a current tuberculosis test at the time that he was admitted. A PPD was administered on February 9, 2009, more than 4 months later.</p> <p>b. Review of Resident #1's February 9, 2009 physical evaluation revealed that it failed to reflect a complete and accurate inventory of his health status as follows:</p> <p>1) The report failed to reflect any Axis I diagnosis. His Health Passport, however, indicated he had schizophrenia. This had been diagnosed in 2005. More recently, on January 23, 2009, a psychiatrist diagnosed "poor impulse control" and prescribed Seroquel 200 mg twice daily "for agitation."</p> <p>2) The February 9, 2009 physical evaluation failed to include the newly-prescribed Seroquel in the listing of current medications.</p>	1500	<p>b. 1. Medical information is shared with PCP and Psychiatrist for appropriate diagnosis.</p>	4-1-09

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I 500	Continued From page 44 3) The February 9, 2009 physical evaluation failed to reflect Resident #1's diagnosis of allergic rhinitis. Review of his Health Passport revealed that his known diagnoses included: obesity, seizure disorder, allergic rhinitis, left hemi-paresis, agenesis of corpus callosum and schizophrenia. 4) On December 2, 2008, a neurologist determined that Resident #1 was allergic to the medication "Topamax (causes hallucinations)". Review of the February 9, 2009 physical evaluation, however, revealed that the physician had placed a check mark indicating "None" for known "Allergies/Drug or Food". 5) The physician had left blank the space on the evaluation form designated for recording the resident's weight. The physician had, however, written "obese" under the resident's General Appearance. There was no evidence that the resident was weighed by the physician during the February 9, 2009 physical evaluation. Further review of the resident's medical chart also failed to show evidence that he had been weighed by a nurse or other facility staff since he was admitted more than 4 months earlier. 6) The February 9 2009 physical evaluation failed to reflect Resident #1's Hepatitis B immunization status and/or vaccination history. At 3:26 PM, interview with the House Manager and Registered Nurse confirmed that the resident's Hepatitis B status had not been assessed. c. Cross-refer to I390.2 Resident #1's records included a November 29, 2007 dental evaluation (report not signed) that reflected "inflamed gingiva, gingivitis" and decay in tooth #16 (as per	I 500	2. Medication listing updated 3. Diagnosis of Allergic Rhinitis forwarded to PCP 4. Diagnosis of allergy to medication forwarded and corrected by PCP 5. Person weights will be recorded monthly and Nutritionist will do consultation and staff training on person #1 diet 6. Person #1 immunization and vaccination history forwarded to home c. See Response to I 390 #2	3-27-09 3-26-09 3-26-09 4-15-09 3-18-09

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1500	Continued From page 45 chart). Resident #1's most recent Individual Support Plan (ISP), dated March 27, 2008, held a recommendation that he receive "comprehensive dental treatment ... scheduled 6 months". There was no evidence that he had been evaluated by a dentist since November 2007. At 3:27 PM, the HM acknowledged that Resident #1 had not been evaluated by a dentist since his September 2008 admission. She further indicated that he was without a designated dentist; the other residents' dentist reportedly was not accepting new patients. 3. The facility failed to demonstrate protection of residents' rights to be free from unnecessary or excessive medication; specifically, psychotropic medications. [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h), as follows: On February 18, 2009, at approximately 8:40 AM, interview with House Manager (HM) revealed that Resident #1 had recently been seen by a psychiatrist and had a new psychotropic medication (Seroquel) added to his regimen. The resident already had been receiving Risperdal. Further interview with the HM revealed that Resident #1's aunt was very involved in his care. Moments later, the HM presented a consultation form on which the psychiatrist had diagnosed "312.30 poor impulse control" and prescribed Seroquel 200 mg twice daily. The resident's aunt reportedly asked the HM why a new medication was being added. After the HM explained what she had learned from the psychiatrist, the aunt reportedly "said OK." Beginning at approximately 12:05 PM, review of Resident #1's most recent Individual Support Plan (ISP), dated March 27, 2008, confirmed that	1500	Medical (resident) team and medical review with possible side effects will be completed with guardian A"	3-27-09

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I 500	Continued From page 46 his aunt had attended the meeting. According to the ISP, the resident did not show capacity for "granting, refusing and/or withdrawing consent to medical treatment..." The HM indicated that the aunt was his designated surrogate health care decision maker. Resident #1's Health Passport listed the following medications that were administered twice daily: Risperdal 2 mg, Depakote ER 500 mg, Keppra 750 mg and Lamictal 50 mg. However, further review of the record failed to show evidence that the GHMRP had obtained written, informed consent from Resident #'s aunt. At 5:55 PM, review of the facility's policies on Informed Consent revealed the following: "Consent is needed for the following procedures: ... restrictive procedures... administration of medications... For non-emergency consents for health care, the Support Coordinator and the Nurse will facilitate the obtaining of consent... contact involved family member..." During the Exit Conference, at approximately 5:30 PM, the RN indicated that she had not attempted to reach Resident #1's aunt to obtain consent for his prescribed medications. There was no evidence that the GHMRP followed established policies and guidelines to ensure that its residents received only those medications that the individual's legal representative agreed to as necessary and least restrictive.	I 500	All medication changes will also be presented to Human Rights Committee for approval.	3-26-09