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

PRINTED: 10/13/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G123		C 10/01/2009

NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS On September 30, 2009 HRLA received an e-mail from Department on Disability Services (DDS) that indicated concerns related to the health and safety of clients residing in the facility. Attached to the e-mail was a report from a nurse consultant with Universal Legal Services (ULS) monitoring team that alleged observing significant deficiencies as specified below: 1. Client #1 was hospitalized from 9/15/09-9/23/09. Since the hospital discharge, the class member had not been seen by the primary care physician (6 days). 2. Client #1's physician's orders were not signed (5 days post hospital discharge) and were handwritten across multiple unnumbered pages. The nurse consultant alleged that the format presented a safety hazard for poor communication between the prescribing physician and the nursing staff that would essentially need implement the orders. 3. Discrepancies were noted between the Dilantin order on the unsigned Physician's Order Form, and the medication administration record regarding the amount of time between discontinuing the tube feeding and the administration of Dilantin for Client #1. 4. Major discrepancies in the dietary orders for Client #1 (post discharging) were noted between the hospital and the facility. 5. The facility nursing staff appeared to be unfamiliar with the scale and accurate weighing procedures. Additionally, the report indicated that nursing staff required further training in weighing	W 000	Received 11/6/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DRS (X6) DATE: 10/13/09

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 000	Continued From page 1 techniques. Reportedly, on September 23, 2009, after discharge from the hospital, Client #1 was weighed by facility staff at 62 lbs. Six days later, the client was weighed again and her weight was documented as 61 lbs (one pound below her Healthy Weight Range). Due to the nature of this complaint, on September 30, 2009, State Survey Agency (SA) initiated an onsite investigation. The findings of the investigation were based on observations in the group home, interviews with the facility staff, and review of facility's records, including unusual incident reports, investigative, and administrative records. As a result of the preliminary investigative findings, the SA determined the results of the investigation revealed that the facility failed to maintain compliance with the Conditions of Participation of Governing Body and Health Care Services, and the facility's nursing services posed likely harm to clients residing in the facility. On September 30, 2009, at approximately 4:30 p.m., prior to the conclusion of the investigation, the facility's Qualified Mental Retardation Professional (QMRP), Director of Nursing, Registered Nurse Supervisor and on duty Licensed Practical Nurse were notified of the immediate jeopardy. On October 1, 2009, at approximately 2:00 a.m. the facility's President, Director of Residential Services (DRS), and Director of Nursing faxed to the SA a plan of correction to address the immediate jeopardy. The SA's Program Manager held a telephone conference with the facility's DRS and President from approximately 3:00 AM to 4:00 AM to discuss the plan of correction and	W 000		

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W 000	Continued From page 2 informed the facility that compliance and implementation of corrected actions must be observed prior to the removal of the immediate leopardy. The following was the plan submitted by the facility that outlined the proposed corrective measures: 1. Accurate documentation of fluid intake (G-tube feeding, water flushes, and medication administration flush) in accordance with physician orders and nutritional recommendations. 2. Mealtime protocol- ensuring consistent with POS, nutrition recommendations. 3. Weigh monitoring use of scale and how to properly weigh individuals. 4. Appropriate transcription of physicians' orders. 5. Adherence to medication administration policy. 6. All nurses in the home will receive additional training on documentation and communication between primary care physician, nurses and staff post hospitalization/emergency room visit, 7. Improve coordination and communication between ATS staff and nurses during medication administration and routine ADL/Hygiene care. 8. Training for the weekend nurses will be completed by October 5, 2009. 9. On September 30, 2009, [Dietitian Name], RDLD re-assessed [Client #1] and recommended the following prescription which was concurred by the PCP: Osmolite 1.2@60cc/hr x 10 hours (7 PM-5AM), Flush with 250 cc water (6 AM, 10 AM,	W 000		

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W 000	Continued From page 3 2 PM, 6 PM, 10 PM) 20cc water flush before and after meds with 5 cc water flush between meds. 10. PCP is required to sign and date telephone order within 24 hours. 11. PCP is required to communicate to the DON or designee coverage for medical services in his absence. 12. Appropriate personnel action will be taken in all instances where a determination is reached that an employee has violated regulatory requirements and/or IDI policies and procedures. 12. The new scale was ordered and will be shipped to the home on October 2, 2009.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review the facility's governing body failed to maintain general operating direction over the facility. [See W104 and W331]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure each client ' s health and safety. [See also W318]	W 102	W102 **This Condition of participation will be met as evidenced by:** The governing body has taken specific measures to ensure that the facility maintain general operating direction over the facility as evidenced by the responses outlined in W104 and W331. The governing body currently is undergoing critical analysis and evaluation and developing strategies and interventions to address and resolve the systemic problems. (see W318)	10/13/09 ongoing
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy,	W 104		

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W 104	Continued From page 4 budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility's governing body failed to provide general operating directions over the facility as evidenced by deficiencies cited throughout this report and the following: The physician failed to sign orders within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13] Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 p.m. revealed Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) within twenty- four (24) hours as required by local regulation: a. September 9, 2009 at 8 p.m.: -Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days; and -Cleanse stomach stoma with NSS, pat dry apply Bacitracin 500 units to G-tube site twice daily, cover with dressing. b. September 13, 2009 at 3:30 p.m.: -Bactrim DS via G-tube BID x 10 days for MRSA. Monitor vital signs twice daily x 10 days. D/C Keflex-bacteria is resistant to Keflex. c. September 14, 2009 at 3:00 p.m.:	W 104	**W 104** **This Standard will be met as evidenced by:** The Health Care Policy and Procedures Manual has been updated in accordance to required local regulation to include physician's signature within 24 hours. The LPN must coordinate with the PCP to obtain the required signatures within the allocated timelines. DON will provide training to LPN staff on the expected outcomes and policy updates. The RN will provide sufficient operating direction over the facility staff as evidenced by record reviews, observations and monitoring of medication administration, review of documentation, training records, and deployment of staff activities, RN and LPN staff will be required to meet	10/20/09 ongoing

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W 104	Continued From page 5 -D/C Bactrim, start Avelox 400 mg QD x 7 days. d. September 23, 2009 at 6:30 p.m.: -Start Peptamen DT @ 50 cc 1 hr x 10 hours from 7 p.m. to 5 a.m. D/C Osmolite 1.2 CAL from 8 p.m. to 6 a.m. @ 30 cc/hrs x 10 hrs. Interview with the Director of Nursing on October 1, 2009 acknowledged that the aforementioned telephone orders from the PCP had not been signed by the PCP within twenty-four hours.	W 104	specific competencies related to job performance. The Director of Nursing will provide ongoing supervision and direction for RN staff and take necessary actions to address systemic and problematic concerns.	
W 114	433.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in clients' records were signed, for one of the three clients included in the sample. (Client #1) The findings include: Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 PM revealed Client #1 had several telephone orders that had been signed but not dated by the facility's Primary Care Physician (PCP) as documented below: On August 31, 2009 at 5 p.m. the PCP ordered via telephone the client to return to her day program and an illness; On September 1, 2009 at 3 p.m. the PCP ordered	W 114	114 **This Standard will be met as evidenced by:** The Director of Nursing has requested that that PCP sign and date all entries in the client's record. The RN assigned to the specific site will be expected to review, report and follow-up with the PCP whenever discrepancies are noted. The governing body will develop and implement written policies and procedures to support these actions.	10-6-09 ongoing

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W 114	Continued From page 6 via telephone to discontinue Peptamen DT @ 40 cc/hr x 10 hours from 7 p.m. until 5 a.m.; and On September 1, 2009 at 3 p.m. PCP ordered via telephone that the client Start Peptamen DT @ 50 cc 1 hour x 10 hours from 7 p.m. until 5 a.m. Interview with the Register Nurse on September 30, 2009 failed to provide an explanation as to why the physician had not dated the orders.	W 114		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) The findings include: The facility failed to have a policy to ensure that physician's telephone orders were signed within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13]. Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 p.m. revealed Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) within twenty- four (24) hours as required by local regulation:	W 149	W149 This Standard will be met as evidenced by: Reference responses to W114.	10-9-09 ongoing

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W 149	Continued From page 7 a. September 9, 2009 at 8 p.m. -Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days; -Cleanse stomach stoma with NSS, pat dry apply Bacitracin 500 units to G-tube site twice daily, cover with dressing. b. September 13, 2009 at 3:30 p.m. -Bactrim DS via G-tube BID x 10 days for MRSA. Monitor vital signs twice daily x 10 days. D/C Keflex-bacteria is resistant to Keflex. c. September 14, 2009 at 3:00 p.m. -D/C Bactrim, start Avelox 400 mg QD x 7 days. d. September 23, 2009 at 6:30 p.m. -Start Peptamen DT @ 50 cc 1 hr x 10 hours from 7 p.m. to 5 a.m. D/C Osmolite 1.2 CAL from 8 p.m. to 6 a.m. @ 30 cc/hrs x 10 hrs. Interview with the Director of Nursing on October 1, 2009 acknowledged that the aforementioned telephone orders from the PCP had not been signed by the PCP within twenty-four hours.	W 149		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee providing	W 192		

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W 192	Continued From page 8 nursing services was trained to competently transcribe orders, assess weights, and, administer G-tube feedings. This failure posed likely harm to all clients' health. The findings include: 1. The facility's nursing services failed to ensure that each licensed staff had received training on procedures to accurately measure the clients' body weight. Client #1 had a decrease in her body weight from 88.7 pounds in March 2009 to 62 pounds in April 2009. The client, as of September 29, 2009, had lost an additional pound, placing her below her Healthy Weight Range (HWR 62-82 lbs). On September 30, 2009, beginning at 8:45 p.m., interviews were conducted with the RN supervisor and Director of Nursing to ascertain more information. According to RN Supervisor, weight variations had been documented for several of the clients residing in the facility and it was suspected that weight's had not been completed and/or measured accurately in previous months. The RN supervisor further indicated that the weighing policy had been revised to ensure accuracy of weights and to identify measures to enact if warranted. The Director of Nursing (DON) revealed that the Supervisory nursing staff had provided training to the nursing staff on the correct policy and procedure for measuring clients' body weights, to include calibration of the scale to ensure that the scale was accurately measuring weight. Earlier interview with the LPN and the QMRP on September 30, 2009 revealed that a new scale,	W 192	W192 **This Standard will be met as evidenced by:** 1. The Director of Nursing will develop and implement competency level training to include but not limited to; accurate and timely transcription of orders, medication administration, weights, g-tube feedings, measuring, and adherence to physician orders. The Director of Nursing will maintain copies of all completed trainings. The RN at the designated site will routinely observe the weighing process and document the nurse's competencies. The nurses had been previously trained in August 2009 by the Director of Nursing.	10-12-09 ongoing

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W 192	Continued From page 9 recommended by the Interdisciplinary Team (IDT) had been ordered, but had not been received. The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she failed to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Client #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a,b,c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately.	W 192	The Director of Nursing in collaboration with training department is currently developing a tracking tool document the training completed by each individual nurse. The assigned RN's will be expected to conduct additional training, whenever identified needs arise as a result of monitoring and oversight. 2. Reference response to #1. The Director of Nursing will continue to forward copies of all completed trainings to the group home site. The Director of Nursing will also maintain a copy as a back-up.	10.7.09 ongoin

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W 192	Continued From page 10 a. Review of Client #1's record on September 30, 2009 evidenced physician orders (dated September 1, 2009, and September 9, 2009, September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the clients' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009, on the importance of transcribing physician orders' accurately. Review of the in-service training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing inservice training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Client #2 and #3, as ordered by the Primary Care Physician (PCP). Review of Clients #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Client #2's physician orders verified the	W 192	**W192, Continued...** 3. Cross reference response to W331 (#1.a.b.c.) The nurses have participated in training on transcription of physician orders and procedures to properly calculate fluid restrictions. The Director of Nursing will continue to schedule and coordinate training with incoming nursing staff and provideongoing training thereafter. Corrective actions will be taken for employees who fail to consistently participate and meet the training requirements. The RN assigned to the designated home will review all fluid records on a consistent basis check for accuracy and/or discrepancies.	10/7/09 MGomy

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W 192	Continued From page 11 client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the client ' s total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client ' s total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training	W 192	a. The Director of Nursing (DON) will deploy and assign RN staff to focus and review specific areas and will increase on-site reviews at the home to further ensure compliance with this standard. b. The Director of Nursing currently sends training records to the home site for filing. Director of Nursing will review and develop a more effective system to ensure that verification of training is appropriately filed in the home and available for review. The Director of Nursing in collaboration with the Training Director continues to maintain master copies off site.	10.12.09 ongoing

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PRINTED: 10/13/2009
FORM APPROVED
OMB NO. 0938-0391

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	09G123		C 10/01/2009

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W 192	Continued From page 12 book, subsequent review of the training records failed to show evidence of said training on fluid intake/restrictions.	W 192	W318	
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; the facility failed to assure that all drugs are administered in compliance with the physician's orders [Refer to W368]; and the facility failed to ensure that nurses were were competent to provide nursing services [Refer to W192]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	This Condition will be met as evidenced by: Reference responses to W331, W368, and W192. The Medical Director in coordination with the Director of Nursing will continue to evaluate and assess and implement policies and directives to ensure health care practices met the required standards. Both will work toward improving clinical documentation, timely follow-up and monitoring, and implementation of monitoring tools to more effectively measure health care services. This will be evidenced by competency reviews, record reviews, on site visitations, and performance evaluations.	10/12/09
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for three of three clients in the sample. (Client #1, Client #2 and Client #3)	W 331		

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W 331	Continued From page 13 The findings include: 1. The nursing staff failed to transcribe Client #1's physician's orders accurately, which could likely pose a risk to the clients' health as evidence by the following: a. Interview with the nursing supervisor on September 30, 2009 at 8:45 a.m. revealed that Client #1 was hospitalized from September 15, 2009 through September 23, 2009 for elevated temperature and PEG tube infection. Further interview revealed that the RN supervisor had contacted the Primary Care Physician (PCP) upon the client's return to the group home and received an order to "resume all previous orders". Review of Client #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, T.O. (telephone order) PCP reviewed by RN supervisor 9/23/09." Additional handwritten orders, dated September 23, 2009 were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had not transcribed the telephone order from the PCP when it was given to her. On 9/30/09 at approximately 3:30 p.m. contact was made with the PCP via phone which verified that he had given the RN supervisor a telephone order to resume all previous orders. At the time of the investigation, the facility's RN failed to transcribe telephone orders as given.	W 331		

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W 331	Continued From page 14 b. Review of a physician order dated September 1, 2009 at approximately 8:55 am revealed the client was to receive Dilantin chewable tablets (U-D 50 mg tablets), 2 tablets crushed via G tube everyday at 7 a.m. for seizure disorder, hold tube feeding for 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the client was receiving her G-tube feeding from 6 p.m. to 6 a.m. Review of the Medication Administration Record (MAR), however, revealed that the client was being administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 AM. In an interview with the RN Supervisor at 9:05 a.m. , she acknowledge that Client #1 was administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 a.m. c. Review of the Client #1's records at approximately 10:45 a.m. revealed a physician order, dated September 1, 2009. According to the physician's order, the client was prescribed Dilantin 2 tabs (100 mg) crushed via G-tube for seizure disorder. Review of the September 2009 MAR; however, documented the transcription of the order on September 29, 2009 as Dilantin (chewable)U-D 50 mg tab, 20 tablets (100 mg) crushed via G-tube for seizure disorder. The MAR was signed by a nurse on September 30, 2009 indicating the order for 20 tablets had been administered. Interview with the RN supervisor at approximately 10:45 a.m. acknowledge the order for 20 tablets of Dilantin crushed via G-tube for seizure disorder had been transcribed instead of Dilantin (chewable) U-D 50 mg tab, 2 tablets (100 mg) crushed via G-tube everyday .	W 331		

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W 331	Continued From page 15 2. The nursing staff failed to calculate Client #1's G-Tube flushes in accordance with physician orders which could likely pose a risk to the clients' health and safety as evidence by: Review of the Client #1's medical record revealed a physician order, dated September 1, 2009. According to the order, the client was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid Intake Monitoring Sheet for G-Tube, dated September, 2009, revealed that the nurses documented completing 70 cc of water flushes, which did not correspond to the number of times medication was administered. The Director of Nursing (DON) could not explain the discrepancy. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility nursing staff were completed the flushes incorrectly. 3. The nursing staff failed to clarify Client #1's physician telephone orders accurately, which could likely pose a risk to the clients' health and safety as evidence by: a. Review of Client #1's records revealed a telephone order, dated September 29, 2009. According to the client's physician's telephone order, the client was prescribed " Osmolyte 1.2 at 30 cc/hr, 1 can every 6 hours from 6 a.m. - 6 p.m. (total of 3 cans per day) with 2 packages of Procel a day or 909 kcals, 49 gm protein, 580 ml of water a day " . The nurse failed to clarify how	W 331		

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W 331	Continued From page 16 to administer three cans of feedings with the restriction of one can every six hours during her 12 hour continuous feed. Furthermore, the nurse failed to identify the exact type and amount of Protein supplement to be administered with the client's continuous feed. It should be noted that interview with the Director of Nursing at approximately 5:30 p.m. acknowledged that three cans of the Osmolyte 1.2 could not be administered in total at the prescribed rate within the specified 12 hour feeding cycle. b. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days. Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. 4. The facility nurses failed to administer Client #1's prescribed G-tube feeding at scheduled time. On September 30, 2009 at approximately 6:00 p.m. Client #1 was observed laying in her bed, at approximately a 30 degree angle and was not receiving her 6 p.m. continuos G-tube feeding. At approximately 6:15 p.m., the Department of Health surveyors informed the Director of Residential Services that Client #1's prescribed feeding had not been administered at the prescribed time. At approximately 6:35 PM the LPN #2 was observed administering 2 cans	W 331	**W331** **This Standard will be met as evidenced by:** Director of Nursing conducted follow-up corrective actions for the RN who failed to transcribe telephone orders as given. The Director of Nursing will provide additional training for all RN staff to include but not limited to; ongoing supervision requirements, timely assessments/follow-up, documentation and communications with the PCP. The RN will conduct assessments at discharge for each individual and document in the record.	10-2-09 ongoing

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W 331	Continued From page 17 Osmolite 1.2 cal at 30 cc/hr. 5. The facility nurses failed to update Client #1's Health Management Care Plan (HMCP). a. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the client had "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:00 a.m. revealed Client #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection. b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Client #1 was hospitalized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection. Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Client #1's HMCP was not updated to include the treatment for elevated temperature and PEG tube infection.	W 331	The RN will review physician orders against the MAR to ensure accuracy. The RN will address all concerns and follow-up with the PCP as needed. The Director of Nursing will provide further review of random records to further ensure ongoing compliance with this standard. The individual no longer resides at the home. The RN in coordination with the Director of Nursing will monitor implementation of the POS, provide training on g-tube feedings, medication administration to include competency reviews.	10-13-09 ongoing

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W 331	Continued From page 18 Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:35 a.m. acknowledged that the HMCP had not been updated to include the hospitalization for elevated temperature and PEG tube infection. There was no evidence that the HMCP had been updated since August 25, 2009. 6. The facility nurses failed to accurately implement Client #2 and #3's fluid restriction. Review of Clients #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Client #2's physician orders verified the client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the client ' s total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed.	W 331		

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W 331	Continued From page 19 b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. There was no evidence that fluid restriction requirements were implemented as prescribed.	W 331	W368 This Standard will be met as evidenced by; Reference responses to W331. The RN assigned to the home will review MAR's and POS on a consistent basis and address all concerns i.e. additional training, corrective actions, and follow-up. LPN staff assigned to the home are also expected to review MAR's and report discrepencies to the RN immediately.	10.12.09 ongoing
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of three clients included in the sample. (Client # 1) The finding includes:	W 368		

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W 368	Continued From page 20 1. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated August 25, 2009 at 12 noon revealed that she was diagnosed with a Furuncle (boil). Further review of the medical record revealed a physician order, dated August 25, 2009. According to the physician's order, Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day for 7 days (for upper lip abscess). Although the medication was prescribed for 7 days, the August 2009 MAR indicated that Bactrim OS Suspension 20 ml was initially administered on August 26, 2009 at a.m. and discontinued on September 2, 2009 at 7 p.m. (8 days). Interview with the RN Supervisor at approximately 12:15 p.m. acknowledged that Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day. Additionally, the RN verified that the medication had been administered for 8 days. 2. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight one capsule every 6 hours for 7 days." Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered	W 368		

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W 368	Continued From page 21 on September 13, 2009 at 6 p.m. Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs was not documented as administered.	W 368	W368 This Standard will be met as evidenced by; Reference responses to W331. The RN assigned to the home will review MAR's and POS on a consistent basis and address all concerns i.e. additional training, corrective actions, and follow-up. LPN staff assigned to the home are also expected to review MAR's and report discrepencies to the RN immediately.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were available for seven of seven clients residing in the facility. (Client #1, #2, #3, #4, #5 #6, and #7) The finding includes: The facility failed to ensure the prescribed scale was available for use. On September 30, 2009 HRLA received an e-mail from DDS that indicated concerns related to the health and safety of the clients residing at the facility. Allegedly, on September 29, 2009 the nurse consultant requested that Client #1 be weighed during the visit and found that the client weighed 61 lbs on the chair scale. This was the scale	W 436		

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W 436	Continued From page 22 reportedly used on September 23, 2009 when her weight was calculated at 82 pounds. Interview conducted with the RN Supervisor at 8:45 a.m., confirmed that weight variations had been an agency concern and indicated that a new scale had been ordered. She further stated that the home was currently utilizing the old chair scale, which was observed in the wheelchair bathroom located towards the nursing station. Interview conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 9:30 a.m. revealed that a new scale (Detecto 6475 digital chair scale) was recommended by the Registered Dietitian (RD) on September 1, 2009 and ordered. The new scale would be shipped to the group home on October 2, 2009 and during the interim, the old chair scale would continue to be utilized. Documentation for the new scale ordered, however, was not available for verification at the time of the investigation. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility had not acquired the new scale.	W 436	W436 This Standard will be met as evidenced by: The new scale is expected to be delivered within a day. The Director of Nursing has assigned a specific staff to order and maintain follow-up on all equipment orders. Documentation will be maintained to track and verify follow-up actions taken to secure equipment in a timely manner.	10-23-09 DNX,QMRP

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 10/01/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019		

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I 000	INITIAL COMMENTS On September 30, 2009 HRLA received an e-mail from Department on Disability Services (DDS) that indicated concerns related to the health and safety of Residents residing in the facility. Attached to the e-mail was a report from a nurse consultant with Universal Legal Services (ULS) monitoring team that alleged observing significant deficiencies as specified below: 1. Resident #1 was hospitalized from 9/15/09-9/23/09. Since the hospital discharge, the class member had not been seen by the primary care physician (6 days). 2. Resident #1's physician's orders were not signed (5 days post hospital discharge) and were handwritten across multiple unnumbered pages. The nurse consultant alleged that the format presented a safety hazard for poor communication between the prescribing physician and the nursing staff that would essentially need implement the orders. 3. Discrepancies were noted between the Dilantin order on the unsigned Physician's Order Form, and the medication administration record regarding the amount of time between discontinuing the tube feeding and the administration of Dilantin for Resident #1. 4. Major discrepancies in the dietary orders for Resident #1 (post discharging) were noted between the hospital and the facility. 5. The facility nursing staff appeared to be unfamiliar with the scale and accurate weighing procedures. Additionally, the report indicated that nursing staff required further training in weighing techniques. Reportedly, on September 23, 2009,	I 000		

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	after discharge from the hospital, Resident #1 was weighed by facility staff at 62 lbs. Six days later, the Resident was weighed again and her weight was documented as 61 lbs (one pound below her Healthy Weight Range). Due to the nature of this complaint, on September 30, 2009, State Survey Agency (SA) initiated an onsite investigation. The findings of the investigation were based on observations in the group home, interviews with the facility staff, and review of facility's records, including unusual incident reports, investigative, and administrative records. As a result of the preliminary investigative findings, the SA determined the results of the investigation revealed that the facility failed to maintain compliance with the Conditions of Participation of Governing Body and Health Care Services, and the facility's nursing services posed likely harm to Residents residing in the facility. On September 30, 2009, at approximately 4:30 p.m., prior to the conclusion of the investigation, the facility's Qualified Mental Retardation Professional (QMRP), Director of Nursing, Registered Nurse Supervisor and on duty Licensed Practical Nurse were notified of the immediate jeopardy. On October 1, 2009, at approximately 2:00 a.m. the facility's President, Director of Residential Services (DRS), and Director of Nursing faxed to the SA a plan of correction to address the immediate jeopardy. The SA's Program Manager held a telephone conference with the facility's DRS and President from approximately 3:00 AM to 4:00 AM to discuss the plan of correction and informed the facility that compliance and implementation of corrected actions must be			

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I 000	Continued From page 2 observed prior to the removal of the immediate jeopardy. The following was the plan submitted by the facility that outlined the proposed corrective measures: 1. Accurate documentation of fluid intake (G-tube feeding, water flushes, and medication administration flush) in accordance with physician orders and nutritional recommendations. 2. Mealtime protocol- ensuring consistent with POS, nutrition recommendations. 3. Weigh monitoring use of scale and how to properly weigh individuals. 4. Appropriate transcription of physicians' orders. 5. Adherence to medication administration policy. 6. All nurses in the home will receive additional training on documentation and communication between primary care physician, nurses and staff post hospitalization/emergency room visit, 7. Improve coordination and communication between ATS staff and nurses during medication administration and routine ADL/Hygiene care. 8. Training for the weekend nurses will be completed by October 5, 2009. 9. On September 30, 2009, [Dietitian Name], RDLD re-assessed [Resident #1] and recommended the following prescription which was concurred by the PCP: Osmolite 1.2@60cc/hr x 10 hours (7 PM-5AM), Flush with 250 cc water (6 AM, 10 AM, 2 PM, 6 PM, 10 PM) 20cc water flush before and after meds with 5 cc water flush between meds.	I 000		

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	10. PCP is required to sign and date telephone order within 24 hours.			
	11. PCP is required to communicate to the DON or designee coverage for medical services in his absence.			
	12. Appropriate personnel action will be taken in all instances where a determination is reached that an employee has violated regulatory requirements and/or IDI policies and procedures.			
	12. The new scale was ordered and will be shipped to the home on October 2, 2009.			
I 229	3510.5(f) STAFF TRAINING	I 229		
	Each training program shall include, but not be limited to, the following:		1229	
	(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;		**3510.5 (f)** **This Statute will be met as evidenced by:**	10-23-09 ongoing
	This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee providing nursing services was trained to competently transcribe orders, assess weights, and, administer G-tube feedings. This failure posed likely harm to all residents' health.		Reference responses to W192, W331, W114, and W318	
	The findings include:			
	1. The facility's nursing services failed to ensure that each licensed staff had received training on procedures to accurately measure the clients'			

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I 229	Continued From page 4 body weight. Resident #1 had a decrease in her body weight from 88.7 pounds in March 2009 to 62 pounds in April 2009. The client, as of September 29, 2009, had lost an additional pound, placing her below her Healthy Weight Range (HWR 62-82 lbs). On September 30, 2009, beginning at 8:45 p.m., interviews were conducted with the RN supervisor and Director of Nursing to ascertain more information. According to RN Supervisor, weight variations had been documented for several of the clients residing in the facility and it was suspected that weight's had not been completed and/or measured accurately in previous months. The RN supervisor further indicated that the weighing policy had been revised to ensure accuracy of weights and to identify measures to enact if warranted. The Director of Nursing (DON) revealed that the Supervisory nursing staff had provided training to the nursing staff on the correct policy and procedure for measuring clients' body weights, to include calibration of the scale to ensure that the scale was accurately measuring weight. Earlier interview with the LPN and the QMRP on September 30, 2009 revealed that a new scale, recommended by the Interdisciplinary Team (IDT) had been ordered, but had not been received. The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she failed to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN	I 229		

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I 229	Continued From page 5 failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Resident #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a.b.c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately. a. Review of Resident #1's record on September 30, 2009 evidenced physician orders (dated September 1, 2009, and September 9, 2009, September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the residents' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009, on the importance of transcribing physician orders' accurately. Review of the in-service	I 229		

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I 229	Continued From page 6 training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing inservice training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Resident #2 and #3, as ordered by the Primary Care Physician (PCP). Review of Resident #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Resident #2's physician orders verified the client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the resident's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid	I 229		

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I 229	Continued From page 7 daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client ' s total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on fluid intake/restrictions.	I 229	1291	
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in residents' records were signed, for one of the three clients included in the sample. (Resident #1)	I 291	3514.2 **This Statute will be met as evidenced by:** Reference responses to W104, 114, W192	

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I 291	Continued From page 8 The findings include: Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 PM revealed Resident #1 had several telephone orders that had been signed but not dated by the facility's Primary Care Physician (PCP) as documented below: On August 31, 2009 at 5 p.m. the PCP ordered via telephone the client to return to her day program and an illness; On September 1, 2009 at 3 p.m. the PCP ordered via telephone to discontinue Peptamen DT @ 40 cc/hr x 10 hours from 7 p.m. until 5 a.m.; and On September 1, 2009 at 3 p.m. PCP ordered via telephone that the client Start Peptamen DT @ 50 cc 1 hour x 10 hours from 7 p.m. until 5 a.m. Interview with the Register Nurse on September 30, 2009 failed to provide an explanation as to why the physician had not dated the orders.	I 291		
I 401	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 observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care	I 401	**1401** **3520.3** **This Statute will be met as evidenced by;** Reference responses to W102, W104, W331, W318.	10-13-09 ongoing

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I 401	Continued From page 9 monitoring and identify services in accordance with clients' needs, for three of three residents in the sample. (Resident #1, Resident #2 and Resident #3) The findings include: 1. The nursing staff failed to transcribe Resident #1's physician's orders accurately, which could likely pose a risk to the clients' health as evidence by the following: a. Interview with the nursing supervisor on September 30, 2009 at 8:45 a.m. revealed that Resident #1 was hospitalized from September 15, 2009 through September 23, 2009 for elevated temperature and PEG tube infection. Further interview revealed that the RN supervisor had contacted the Primary Care Physician (PCP) upon the client's return to the group home and received an order to "resume all previous orders". Review of Resident #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, T.O. (telephone order) PCP reviewed by RN supervisor 9/23/09." Additional handwritten orders, dated September 23, 2009 were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had not transcribed the telephone order from the PCP when it was given to her. On 9/30/09 at approximately 3:30 p.m. contact was made with the PCP via phone which verified that he had given the RN supervisor a telephone	I 401		

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I 401	Continued From page 10 order to resume all previous orders. At the time of the investigation, the facility's RN failed to transcribe telephone orders as given. b. Review of a physician order dated September 1, 2009 at approximately 8:55 am revealed the client was to receive Dilantin chewable tablets (U-D 50 mg tablets), 2 tablets crushed via G tube everyday at 7 a.m. for seizure disorder, hold tube feeding for 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the client was receiving her G-tube feeding from 6 p.m. to 6 a.m. Review of the Medication Administration Record (MAR), however, revealed that the client was being administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 AM. In an interview with the RN Supervisor at 9:05 a.m. , she acknowledge that Resident #1 was administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 a.m. c. Review of the Resident #1's records at approximately 10:45 a.m. revealed a physician order, dated September 1, 2009. According to the physician's order, the client was prescribed Dilantin 2 tabs (100 mg) crushed via G-tube for seizure disorder. Review of the September 2009 MAR; however, documented the transcription of the order on September 29, 2009 as Dilantin (chewable)U-D 50 mg tab, 20 tablets (100 mg) crushed via G-tube for seizure disorder. The MAR was signed by a nurse on September 30, 2009 indicating the order for 20 tablets had been administered. Interview with the RN supervisor at approximately 10:45 a.m. acknowledge the order for 20 tablets of Dilantin crushed via G-tube for seizure disorder had been transcribed instead of	I 401		

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I 401	Continued From page 11 Dilantin (chewable) U-D 50 mg tab, 2 tablets (100 mg) crushed via G-tube everyday . 2. The nursing staff failed to calculate Resident #1's G-Tube flushes in accordance with physician orders which could likely pose a risk to the clients' health and safety as evidence by: Review of the Resident #1's medical record revealed a physician order, dated September 1, 2009. According to the order, the resident was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid Intake Monitoring Sheet for G-Tube, dated September, 2009, revealed that the nurses documented completing 70 cc of water flushes, which did not correspond to the number of times medication was administered. The Director of Nursing (DON) could not explain the discrepancy. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility nursing staff were completed the flushes incorrectly. 3. The nursing staff failed to clarify Resident #1's physician telephone orders accurately, which could likely pose a risk to the clients' health and safety as evidence by: a. Review of Resident #1's records revealed a telephone order, dated September 29, 2009. According to the client's physician's telephone order, the client was prescribed " Osmolyte 1.2 at 30 cc/hr, 1 can every 6 hours from 6 a.m. - 6 p.m. (total of 3 cans per day) with 2 packages of	I 401		

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I 401	Continued From page 12 Procel a day or 909 kcals, 49 gm protein, 580 ml of water a day " . The nurse failed to clarify how to administer three cans of feedings with the restriction of one can every six hours during her 12 hour continuous feed. Furthermore, the nurse failed to identify the exact type and amount of Protein supplement to be administered with the resident's continuous feed. It should be noted that interview with the Director of Nursing at approximately 5:30 p.m. acknowledged that three cans of the Osmolyte 1.2 could not be administered in total at the prescribed rate within the specified 12 hour feeding cycle. b. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended Keflex 500 mg Twenty eight one capsule every 6 hours for 7 days. Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. 4. The facility nurses failed to administer Resident #1's prescribed G-tube feeding at scheduled time. On September 30, 2009 at approximately 6:00 p.m. Resident #1 was observed laying in her bed, at approximately a 30 degree angle and was not receiving her 6 p.m. continuos G-tube feeding. At approximately 6:15 p.m., the Department of Health surveyors informed the Director of Residential Services that Resident #1's prescribed feeding had not been administered at	I 401		

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I 401	Continued From page 13 the prescribed time. At approximately 6:35 PM the LPN #2 was observed administering 2 cans Osmolite 1.2 cal at 30 cc/hr. 5. The facility nurses failed to update Resident #1's Health Management Care Plan (HMCP). a. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the client had "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:00 a.m. revealed Resident #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection. b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Resident #1 was hospitalized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection. Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Resident #1's HMCP was not updated to include the treatment	I 401		

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I 401	Continued From page 14 for elevated temperature and PEG tube infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:35 a.m. acknowledged that the HMCP had not been updated to include the hospitalization for elevated temperature and PEG tube infection. There was no evidence that the HMCP had been updated since August 25, 2009. 6. The facility nurses failed to accurately implement Resident #2 and #3's fluid restriction. Review of Resident #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Resident #2's physician orders verified the client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the resident's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed.	I 401		

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I 401	Continued From page 15 b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's physician "s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the resident's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. There was no evidence that fluid restriction requirements were implemented as prescribed.	I 401		
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of three residents included in the sample. (Resident # 1) The finding includes:	I 473		

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I 473	Continued From page 16 1. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated August 25, 2009 at 12 noon revealed that she was diagnosed with a Furuncle (boil). Further review of the medical record revealed a physician order, dated August 25, 2009. According to the physician ' s order, Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day for 7 days (for upper lip abscess). Although the medication was prescribed for 7 days, the August 2009 MAR indicated that Bactrim OS Suspension 20 ml was initially administered on August 26, 2009 at a.m. and discontinued on September 2, 2009 at 7 p.m. (8 days). Interview with the RN Supervisor at approximately 12:15 p.m. acknowledged that Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day. Additionally, the RN verified that the medication had been administered for 8 days. 2. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the Resident had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days." Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered on September 13, 2009 at 6 p.m.	I 473		

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I 473	Continued From page 17 Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs was not documented as administered.	I 473	1473 3522.4 **This Statute will be met as evidenced by:** **Reference response to W104 &W331.** The Director of Nursing has conducted additional training for the LPN staff. The RN assigned to the home will continue to implement training whenever needed. Additional RN's will be hired to provide oversight and monitoring on a daily basis, to ensure that the health care needs of the individuals are met. The Director of Nursing will provide monitoring to ensure implementation.	10/13/09 ongoing