

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

PRINTED: 08/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2010
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A re-certification survey was conducted from 7/15/2010 to 7/16/2010. A random sampling of three clients was selected from a population of three females and two males with varying degrees of disabilities. This survey was completed utilizing the fundamental survey process. The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	W 000	<i>Reviewed - DO# HRLA-ICFO SEP - 1 2010</i>	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for two of three sampled clients. [Clients #1 and #3] The finding includes: 1. The QMRP failed to ensure staff accurately implemented a client's behavior support plan to prevent increased levels of agitation. [See W193] 2. The QMRP failed to ensure staff consistently implemented a client's feeding protocol and repositioning protocol. [See W194]	W 159	All staff were inserviced on client #1' BSP on . The emphasis of the training was to ensure that staff decrease client #1 level of agitation during mealtime by informing him about what is on his plate and glass. Staff will allow client #1 to taste his foods, and to offer alternative if there appear to be no interest on the food that is offered. Refer to attachment # 1.a Additional training was provided on Refer to attachment #1.b In the future the facility QIDP will ensure that staff are trained on client #1's BSP, and that the training is effective. Refer W 193 P. Attachments # 1, and 2 Refer to W 194 P. 3&4	7-28-10 8-26-10 8-26-10 8-26-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Amyle Brooks* TITLE *CEO* (X6) DATE *9-1-10*

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 193	<p>Continued From page 2</p> <p>blindness. This client's 3/2010 behavior support plan (BSP) also recommends the following intervention to manage his agitation levels:</p> <p>" Before you make available any meal or snack, let him know what is on the plate and in his glass. Encourage him to taste and if there appears to be no interest in the meal/snack, be prepared to offer an alternative. "</p> <p>The facility's staff never explained to Client #1 what was on his plate before he was allowed to begin eating. In addition, Client #1 ' s attempts to touch his food was also being restricted despite him being diagnosed as being legally blind.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP), the house manager (HM) and the director of nursing (DON) on 7/16/2010, at approximately 5:07 p.m., confirmed that Client #1 often attempts to touch his food prior to eating. In addition, the QMRP and the House Manager both agreed to retrain staff on this behavioral intervention.</p> <p>The facility failed to ensure staff effectively implemented Client #1 ' s behavior support plan to manage his level of agitation.</p>	W 193	<p>All staff were inserviced on client #1' BSP on .</p> <p>The emphasis of the training was to ensure that staff decrease client #1 level of agitation during mealtime by informing him about what is on his plate and glass. Staff will allow client #1 to taste his foods, and to offer alternative if there appear to be no interest on the food that is offered.</p> <p>to decrease client #1's level of agitation during mealtime. Staff will</p> <p>Refer to attachment # 1.a</p> <p>Additional training was provided on</p> <p>Refer to attachment #1.b</p> <p>In the future the facility QIDP will ensure that staff are trained on client #1's BSP, and that the training is effective.</p>	7-28-10
W 194	<p>483.430(e)(4) STAFF TRAINING PROGRAM</p> <p>Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff</p>	W 194		8-26-10

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W 194	Continued From page 4 placed on the beanbag. The HM and the QMRP indicated they would meet with the Physical Therapist to clarify his recommendation and to provide additional training.	W 194	The nursing staff was trained on safe medication administration based on best practice in nursing 7-19-10 and 8-06-10.	
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the accurate administration of client's medications for two of three sampled clients. [Clients #2 and #3]</p> <p>The findings include:</p> <p>Observation of the facility's nurse administering the evening medications on 7/15/2010 beginning at 4:30 p.m., revealed the following errors:</p> <p>1. At 7:26 p.m., the nurse poured 12.5 ml of Keppra 100mg solution into a small plastic measuring cup. The nurse then tightened the cap on the bottle of Keppra and placed it in the medicine cabinet. The surveyor reminded the nurse that all medication needed to be verified and then she handed the surveyor the bottle of Keppra to confirm the contents and to whom it was prescribed. Further observation on the same day at approximately 7:28 p.m. revealed Client #3 was prescribed 10 ml of Keppra 100mg solution. This information was relayed to the nurse and she</p>	W 369	<p>The rights to medication administration was strongly emphasized with the nursing staff. henceforth, the RN supervisor will monitor the medication quarterly to ensure that all the individuals' medications are safely administered. Refer to attachment #4.a and 4.b</p> <p>In the future, the nursing staff will ensure that all the individuals's medication are administered as prescribed.</p>	

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W 369	<p>Continued From page 5</p> <p>immediately poured out the excess medication into a small plastic measuring cup and discarded the overage into the small garbage can in the kitchen.</p> <p>2. At 6:54 p.m., Client #2 was provided her evening medication regimen, crushed and served to her in apple sauce. After the first spoon of the medication, Client #2 held the medication in her mouth and was provided a cup of water to drink by the nurse. On the second spoon of medication, Client #2 again held it in her mouth. This time the nurse asked Client #2 to swallow her medications before she would be provided any more water. Client #2 refused to swallow and began to ask the nurse for the cup of water by pointing towards it. As Client #2 continued to refuse to swallow, she began to spit the medication out of her mouth. The nurse scooped up the medication from Client #2 's bib and placed it back in the small plastic container and then tried to get her to re-take the medication. Client #2 again refused. The nurse took the small plastic container and placed it in the medicine cabinet and locked the doors. The nurse then indicated she would attempt to re-administer the medications later on in the evening. There was no way to verify Client #2 received her complete dosage of:</p> <ul style="list-style-type: none"> a. Keppra 500mg Tab b. Calcium 600/D400 Tab c. Ranitidine 150mg Tab d. Tegretol 200mg Tab e. Lipitor 10mg Tab f. Haloperidol 0.5mg Tab <p>3. At approximately 7:20 p.m. Client #3 was provided her medications via G-Tube. The nurse</p>	W 369	<p>Client #2 received all of her prescribed medications on 7-15-10 as ordered. Interview with the nurse (interview conducted by the DON) revealed that the small amount of client#2' medication that she sput out on her bib was wiped out with the napkin that (nurse) had on her hand when she went to administer client #'s medication. The rest of the medication was offered to client #2 and she accepted her medication. The nurse was trained by the DON on 7-19-10 Refer to attachment #4. The emphasis was on the infection control, measures, and medication rights. In the future, the nursing staff will ensure that the individuals' medications are administered in a safe and infection free environment.</p>	7-19-10
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W 369	<p>Continued From page 6</p> <p>was observed to check for negative bowel sounds, then checked for residuals, and then began pouring the dosage of Phenobarbital 20mg/5ml solution. Review of the 7/2010 physician ' s orders (POS) on 7/16/2010 at approximately 6:55 p.m. revealed an order which prescribed the nurse should " flush tube with 20ml of water before and after each medication every shift. Further record review on the same day at approximately 6:59 p.m. revealed Client #3's 4/6/2010 Nutritional assessment further recommended, " flush GT with 20cc water before and after each medication and 5 cc water between each medication every shift ... " The attending nurse failed to either flush with 20ml of water before she began to administer the meds and failed to ensure 5ml of water was provided between each medication as it was poured into the syringe. Client #3 ' s complete evening medication regimen consisted of the following:</p> <ol style="list-style-type: none"> Keppra 100mg Solution - 10 ml Phenobarbital 20mg/5ml Solution - 12.5ml Cal-Carb 1250mg/5ml Solution - 5ml Senna Syrup 8.6mg/5ml Solution - 10ml (At bedtime) Milk of Magnesia - 10ml <p>4. At approximately 7:30 p.m. Client #3's dosage of Senna Syrup 8.6mg/5ml Solution - 10ml was administered via G-Tube. Review of the physician's order sheets (POS) on 7/16/2010 at approximately 6:56 p.m. revealed the medication was prescribed on 6/2/2010 to administered " at bedtime " .</p> <p>Interview with the director of nursing (DON) on 7/16/2010, at 2:31 p.m., confirmed the nurse should have accurately poured Client #3's dosage</p>	W 369	<p>The interview with the attending nurse revealed that she assessed client# 3's bowel sound, then checked the residual prior to flushing the tube with 20cc of water, then poured from a surfile cup into a 30cc medication cup, and flushed. however, the attending medication nurse was inserviced by the DON 7-19-10 and 8-06-10. Refer to attachment #4</p> <p>In the future, the nursing staff will ensure that all the individuals' G-tube medications are administered as prescribed.</p> <p>The nursing staff was trained by the DON on 7-19-10 to ensure that all medications are administered as ordered. Again the rights to medication administration was reinterated during the nursing staff training.</p> <p>In the future, the nursing staff will ensure that all medications are administered according to the nursing best practices.</p>	7-19-10	

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W 369	Continued From page 7 of Kepra, should not have scooped up the medication that was spat out of Client #2's mouth, should have flushed with 20ml of water before she started to administer Client #3 her medications and should have ensured the Senna Syrup should have been administered at bedtime (as prescribed).	W 369		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff provided clients with the prescribed adaptive equipment during meals and when lying down for two of three sampled clients. [Clients #1 and #3]</p> <p>The findings include:</p> <p>1. Observation on 7/15/2010 at approximately 4:30 p.m. (snack) and 6:00 p.m. (dinner) revealed Client #1 used a built-up handled tablespoon during his meals. While Client #1 ate his snack, Staff #1 provided hand over hand assistance during the meal due to him having difficulty managing the food on his spoon. The same problem occurred during dinner and Client #1 again had difficulty managing the food on his</p>	W 436	<p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on</p> <p>Staff were retrained again on</p> <p>Refer to attachment #2</p> <p>Currently client #1 consumes his foods using a teaspoon.</p> <p>In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p>	<p>7-28-10</p> <p>8-16-10</p>

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W 436	<p>Continued From page 8</p> <p>spoon. Staff #2 was also sitting at the dinner table at the time and she advised that Staff #1 provide Client #1 with a teaspoon. Staff #2 indicated that Client #1 does much better with a teaspoon and he is able to eat independently with it. Staff #1 insisted that the larger tablespoon was fine and continued to help Client #1 eat his meal with intermittent hand-over-hand assistance. During the exchange, the facility's house manager (HM) provided the staff at the dinner table with a built-up handled teaspoon for Client #1 to use, but Staff #1 again insisted that the larger spoon was adequate and assisted Client #1 to finish his meal with the larger spoon.</p> <p>Record review on 7/16/2010 at 5:11 p.m. revealed Client #1's 2/17/2010 Speech and Language (SLP) assessment recommended that the facility " Change tablespoon to teaspoon. Reducing size of bowl will reduce amount he will be able to take with each mouthful and will help with quantity of intake. [Client #1] may need a longer handled spoon. "</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) and the house manager (HM) on 7/16/2010, at approximately 5:12 p.m. confirmed Staff #1 should have utilized the smaller spoon during dinner on 7/15/2010.</p> <p>2. Observation on 7/15/2010 at approximately 5:05 p.m. revealed Client #3 was lying in her bed on her back and slightly to her right. A later observation at approximately 5:25 p.m. revealed she was transported from her bed to her wheelchair and transferred to a large beanbag in the living room.</p>	W 436	<p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on Staff were retrained again on Refer to attachment #2 Currently client #1 consumes his foods using a teaspoon. In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p> <p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on Staff were retrained again on Refer to attachment #2 Currently client #1 consumes his foods using a teaspoon. In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p>	<p>7-28-10 8-16-10</p> <p>7-28-10 8-16-10</p>
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W 455	<p>Continued From page 10</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview the facility's nursing staff failed to ensure the implementation of effective infection control methods to ensure the health and safety of one of three sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>[Cross Reference W369]</p> <p>Observations on 7/15/2010 at 6:54 p.m., revealed Client #2 was provided her evening medication regimen, crushed and served to her in apple sauce. During the process, Client #2 refused to swallow and began spit out the medication on to her bib. The nurse scooped up the medication from Client #2's bib and placed it back into the small plastic container and then tried to get her to re-take the medication. Client #2 again refused the medication. The nurse took the small plastic container and placed it in the medicine cabinet and locked the doors. The nurse then indicated she would attempt to re-administer the medications later on in the evening.</p> <p>Interview with director of nursing (DON) on 7/16/2010 at approximately 6:00 p.m. confirmed the medication was not on any shelves in the medication cabinet and that it was administered the night before. Review of the evening nurse's progress notes revealed the medication was administered later in the evening on 7/16/2010 after the initial attempt. There was also no</p>	W 455	<p>Client #2 received all of her prescribed medications on 7-15-10 as ordered. Interview with the nurse (interview conducted by the DON) revealed that the small amount of client#2' medication that she sput out on her bib was wiped out with the napkin that (nurse) had on her hand when she went to administer client #'s medication. The rest of the medication was offered to client #2 and she accepted her medication. The nurse was trained by the DON on 7-19-10 Refer to attachment #4. The emphasis was on the infection control, measures, and medication rights. In the future, the nursing staff will ensure that the individuals' medications are administered in a safe, infection free environment.</p>	7-19-10	

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W 455	Continued From page 11 evidence that a new batch of medication was prepared or that the old set was discarded. As documented by the attending nurse, the condcotion of medication and saliva was administered to the client.	W 455			
W 475	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure clients were provided the correct eating utensils during meals for one of three sampled clients. [Client #1] The finding includes: [Cross Reference W436] Observation on 7/15/2010 at approximately 4:30 p.m. (snack) and 6:00 p.m. (dinner) revealed Client #1 utilized a built-up handled tablespoon to complete his meals. During the meals, Client #1 was observed having difficulty keeping the food on his spoon. He was observed attempting to scoop large portions of food onto his spoon with difficulty. Staff had to provide hand-over-hand assistance and direct intervention for him to complete his meal. Record review on 7/16/2010, at 5:11 p.m. revealed Client #1's 2/17/2010 Speech and Language (SLP) assessment recommended that the facility " Change tablespoon to teaspoon.	W 475	All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on Staff were retrained again on Refer to attachment #2 Currently client #1 consumes his foods using a teaspoon. In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.	7-28-10 8-16-10	

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W 475	<p>Continued From page 12</p> <p>Reducing size of bowl will reduce amount he will be able to take with each mouthful and will help with quantity of intake. [Client #1] may need a longer handled spoon. "</p> <p>The facility failed to ensure Client #1 was provided the correct and prescribed eating utensil during his meals.</p>	W 475	<p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on</p> <p>Staff were retrained again on</p> <p>Refer to attachment #2</p> <p>Currently client #1 consumes his foods using a teaspoon.</p> <p>In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p>	<p>7-28-10</p> <p>8-16-10</p>
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2010
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 183	Continued From page 1 residents with the prescribed adaptive equipment during meals and when lying down. [See Federal Deficiency Citation W436] 4. The QMRP failed to ensure residents were provided the correct eating utensils during meals. [See Federal Deficiency Citation W475]	I 183	Refer to W 436 (1) P. 9 Refer to attachment #3 Refer to W 475 P.12 of 13 Refer to attachment # 2	7-29-10 7-28-10 8-26-10
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation and staff interview the GHMRP's nursing staff failed to ensure the implementation of effective infection control methods to ensure the health and safety of one of three sampled residents. [Resident #2] The finding includes: [Reference Federal Deficiency Citation W455] Observations on 7/15/2010 at 6:54 p.m., revealed Resident #2 was provided her evening medication regimen, crushed and served to her in apple sauce. During the process, Resident #2 refused to swallow and began spit out the medication on to her bib. The nurse scooped up the medication from Resident #2's bib and placed it back into the small plastic container and then tried to get her to re-take the medication. Resident #2 again refused the medication. The nurse took the small plastic container and placed it in the medicine cabinet and locked the doors. The nurse then indicated she would attempt to	I 226	Client #2 received all of her prescribed medications on 7-15-10 as ordered. Interview with the nurse (interview conducted by the DON) revealed that the small amount of client#2' medication that she sput out on her bib was wiped out with the napkin that (nurse) had on her hand when she went to administer client #'s medication. The rest of the medication was offered to client #2 and she accepted her medication. The nurse was trained by the DON on Refer to attachment #4. The emphasis was on the infection control, measures, and medication rights. In the future, the nursing staff will ensure that the individuals' medications are administered in a safe, infection free environment.	7-19-10

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I 226	Continued From page 2 re-administer the medications later on in the evening. Interview with director of nursing (DON) on 7/16/2010 at approximately 6:00 p.m. confirmed the medication was not on any shelves in the medication cabinet and that it was administered the night before. Review of the evening nurse's progress notes revealed the medication was administered later in the evening on 7/16/2010 after the initial attempt. There was also no evidence that a new batch of medication was prepared or that the old set was discarded. As documented by the attending nurse, the concoction of medication and saliva was administered to the resident. The GHMRP failed to ensure nurses effectively implemented infection control measures to ensure the health and safety of its residents.	I 226	Client #2 received all of her prescribed medications on 7-15-10 as ordered. Interview with the nurse (interview conducted by the DON) revealed that the small amount of client#2's medication that she sput out on her bib was wiped out with the napkin that (nurse) had on her hand when she went to administer client #'s medication. The rest of the medication was offered to client #2 and she accepted her medication. The nurse was trained by the DON on 7-19-10 & Refer to attachment #4.a and 4.b 8-06-10 The emphasis was on the infection control, measures, and medication rights. In the future, the nursing staff will ensure that the individuals' medications are administered in a safe, infection free environment.	
I 395	3520.2(e) PROFESSIONAL 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: (e) Nursing: This Statute is not met as evidenced by: Based on observation, staff interview and record	I 395		

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I 395	<p>Continued From page 3</p> <p>review, the GHMRP failed to ensure nurses maintained the accurate administration of resident's medications for two of three sampled residents. [Residents #2 and #3]</p> <p>The findings include:</p> <p>Observation of the GHMRP 's nurse administering the evening medications on 7/15/2010 beginning at 4:30 p.m., revealed the following errors:</p> <p>1. At 7:26 p.m., the nurse poured 12.5 ml of Keppra 100mg solution into a small plastic measuring cup. The nurse then tightened the cap on the bottle of Keppra and placed it in the medicine cabinet. The surveyor reminded the nurse that all medication needed to be verified and then she handed the surveyor the bottle of Keppra to confirm the contents and to whom it was prescribed. Further observation on the same day at approximately 7:28 p.m. revealed Resident #3 was prescribed 10 ml of Keppra 100mg solution. This information was relayed to the nurse and she immediately poured out the excess medication into a small plastic measuring cup and discarded the overage into the small garbage can in the kitchen.</p> <p>2. At 6:54 p.m., Resident #2 was provided her evening medication regimen, crushed and served to her in apple sauce. After the first spoon of the medication, Resident #2 held the medication in her mouth and was provided a cup of water to drink by the nurse. On the second spoon of medication, Resident #2 again held it in her mouth. This time the nurse asked Resident #2 to swallow her medications before she would be provided any more water. Resident #2 refused to swallow and began to ask the nurse for the cup of</p>	I 395	<p>The nursing staff was trained on safe medication administration based on best practice in nursing and</p> <p>The rights to medication administration was strongly emphasized with the nursing staff. henceforth, the RN supervisor will monitor the medication quarterly to ensure that all the individuals' medications are safely administered. Refer to attachment #4.a and 4.b</p> <p>In the future, the nursing staff will ensure that all the individuals's medication are administered as prescribed.</p>	7-19-10 8-06-10.

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I 395	<p>Continued From page 5</p> <p>between each medication as it was poured into the syringe. Resident #3 's complete evening medication regimen consisted of the following:</p> <ul style="list-style-type: none"> a. Keppra 100mg Solution - 10 ml b. Phenobarbitol 20mg/5ml Solution - 12.5ml c. Cal-Carb 1250mg/5ml Solution - 5ml d. Senna Syrup 8.6mg/5ml Solution - 10ml (At bedtime) e. Milk of Magnesia - 10ml <p>4. At approximately 7:30 p.m. Resident #3's dosage of Senna Syrup 8.6mg/5ml Solution - 10ml was administered via G-Tube. Review of the physician's order sheets (POS) on 7/16/2010 at approximately 6:56 p.m. revealed the medication was prescribed on 6/2/2010 to administered " at bedtime " .</p> <p>Interview with the director of nursing (DON) on 7/16/2010, at 2:31 p.m., confirmed the nurse should have accurately poured Resident #3's dosage of Keppra, should not have scooped up the medication that was spat out of Resident #2's mouth, should have flushed with 20ml of water before she started to administer Resident #3 her medications and should have ensured the Senna Syrup should have been administered at bedtime (as prescribed).</p> <p>The GHMRP failed to ensure nurses administered all medications as prescribed.</p>	I 395	<p>Client #2 received all of her prescribed medications on 7-15-10 as ordered. Interview with the nurse (interview conducted by the DON) revealed that the small amount of client#2' medication that she sput out on her bib was wiped out with the napkin that (nurse) had on her hand when she went to administer client #'s medication. The rest of the medication was offered to client #2 and she accepted her medication. The nurse was trained by the DON on 7-19-10 & 8-06-10 Refer to attachment #4.a and 4.b The emphasis was on the infection control, measures, and medication rights. In the future, the nursing staff will ensure that the individuals' medications are administered in a safe, infection free environment.</p>	7-19-10 & 8-06-10
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by:</p>	I 422		

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1422	<p>Continued From page 6</p> <p>Based on observation, staff interview and record review, the GHMRP failed to ensure staff accurately implemented a resident's behavior support plan, feeding protocol and repositioning protocol for two of three sampled residents. [Residents #1 and #3]</p> <p>The finding includes:</p> <p>1. [Reference Federal Deficiency Citation W436]</p> <p>Observation on 7/15/2010, at approximately 4:30 p.m. and 6:00 p.m., revealed Resident #1 attempted to touch his food before eating. On both occasions staff repeatedly asked him "not to touch the food". Resident #1 was observed repeatedly attempting to touch his food despite the staff's requests. On each of the staff attempts to have him not touch his food, Resident #1's level agitation appeared to increase.</p> <p>Record review on 7/16/2010, at 5:05 pm revealed Resident #1's Psychology assessment lists the Axis III diagnoses of cataracts, glaucoma and blindness. This resident's 3/2010 behavior support plan (BSP) also recommends the following intervention to manage his agitation levels:</p> <p>" Before you make available any meal or snack, let him know what is on the plate and in his glass. Encourage him to taste and if there appears to be no interest in the meal/snack, be prepared to offer an alternative. "</p> <p>The GHMRP's staff never explained to Resident #1 what was on his plate before he was allowed to begin eating. In addition, Resident #1 's attempts to touch his food was also being</p>	1422	<p>All staff were inserviced on client #1' BSP on .</p> <p>The emphasis of the training was to ensure that staff decrease client #1 level of agitation during mealtime by informing him about what is on his plate and glass. Staff will allow client #1 to taste his foods, and to offer alternative if there appear to be no interest on the food that is offered.</p> <p>to decrease client #1's level of agitation during mealtime. Staff will</p> <p>Refer to attachment # 1.a</p> <p>Additional training was provided on</p> <p>Refer to attachment #1.b</p> <p>In the future the facility QIDP will ensure that staff are trained on client #1's BSP, and that the training is effective.</p>	<p>7-28-10</p> <p>8-26-10</p>

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I 422	<p>Continued From page 7</p> <p>restricted despite him being diagnosed as being legally blind.</p> <p>Interview with the GHMRP's qualified mental retardation professional (QMRP), the house manager (HM) and the director of nursing (DON) on 7/16/2010, at approximately 5:07 p.m., confirmed that Resident #1 often attempts to touch his food prior to eating. In addition, the QMRP and the House Manager both agreed to retrain staff on this behavioral intervention.</p> <p>The GHMRP failed to ensure staff effectively implemented Resident #1's behavior support plan to manage his level of agitation.</p> <p>2. Observation on 7/15/2010 at approximately 5:05 p.m. revealed Resident #3 was lying in her bed on her back and slightly to her right. A later observation at approximately 5:25 p.m. revealed she was transported from her bed to her wheelchair and transferred to a large beanbag in the living room. Resident #3 was again observed lying on her back and slightly tilted to her right. She was allowed to lay there during the evening hours while the other residents ate dinner.</p> <p>Record review on 7/16/2010 at approximately 6:35 p.m. revealed Resident #3's 10/26/2009 Physical Therapy assessment identified she's diagnosed with having spastic quadriplegia, dislocated left hip and cerebral palsy. The assessment goes to further recommend the following:</p> <p>" DO NOT position [Resident #3] on her back with her lower trunk and legs rotated to the right. Use a hip abduction pad or pillow between her knees while out of the wheelchair. Use pillows under her ankles to keep her heels off the bed.</p>	I 422	<p>All staff were inserviced by the PT on client #3 repositioning on Refer tot attachment #3 As per PT training on 7-29-10, staff must support client #3 with pillows, and align her body. In the future, the house management will ensure the consistent implementation of client #3 repositioning as recommended by the Physical Therapist.</p> <p>All staff were inserviced by the PT on client #3 repositioning on Refer tot attachment #3 As per PT training on 7-29-10, staff must support client #3 with pillows, and align her body. In the future, the house management will ensure the consistent implementation of client #3 repositioning as recommended by the Physical Therapist.</p>	<p>7-29-10</p> <p>7-29-10</p>

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I 430	<p>Continued From page 9</p> <p>Resident #1 used a built-up handled tablespoon during his meals. While Resident #1 ate his snack, Staff #1 provided hand over hand assistance during the meal due to him having difficulty managing the food on his spoon. The same problem occurred during dinner and Resident #1 again had difficulty managing the food on his spoon. Staff #2 was also sitting at the dinner table at the time and she advised that Staff #1 provide Resident #1 with a teaspoon. Staff #2 indicated that Resident #1 does much better with a teaspoon and he is able to eat independently with it. Staff #1 insisted that the larger tablespoon was fine and continued to help Resident #1 eat his meal with intermittent hand-over-hand assistance. During the exchange, the GHMRP's house manager (HM) provided the staff at the dinner table with a built-up handled teaspoon for Resident #1 to use, but Staff #1 again insisted that the larger spoon was adequate and assisted Resident #1 to finish his meal with the larger spoon.</p> <p>Record review on 7/16/2010 at 5:11 p.m. revealed Resident #1's 2/17/2010 Speech and Language (SLP) assessment recommended that the GHMRP " Change tablespoon to teaspoon. Reducing size of bowl will reduce amount he will be able to take with each mouthful and will help with quantity of intake. [Resident #1] may need a longer handled spoon. "</p> <p>Interview with the GHMRP's qualified mental retardation professional (QMRP) and the house manager (HM) on 7/16/2010, at approximately 5:12 p.m. confirmed Staff #1 should have utilized the smaller spoon during dinner on 7/15/2010.</p> <p>3. Observation on 7/15/2010 at approximately 4:30 p.m. (snack) and 6:00 p.m. (dinner) revealed</p>	I 430	<p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on Staff were retrained again on Refer to attachment #2 Currently client #1 consumes his foods using a teaspoon. In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p> <p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on Staff were retrained again on Refer to attachment #2 Currently client #1 consumes his foods using a teaspoon. In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p>	<p>7-28-10 8-16-10</p> <p>7-28-10 8-16-10</p>

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I 430	<p>Continued From page 10</p> <p>Resident #1 utilized a built-up handled tablespoon to complete his meals. During the meals, Resident #1 was observed having difficulty keeping the food on his spoon. He was observed attempting to scoop large portions of food onto his spoon with difficulty. Staff had to provide hand-over-hand assistance and direct intervention for him to complete his meal.</p> <p>Record review on 7/16/2010, at 5:11 p.m. revealed Resident #1's 2/17/2010 Speech and Language (SLP) assessment recommended that the GHMRP " Change tablespoon to teaspoon. Reducing size of bowl will reduce amount he will be able to take with each mouthful and will help with quantity of intake. [Resident #1] may need a longer handled spoon."</p> <p>The GHMRP failed to ensure Resident #1 was provided the correct and prescribed eating utensil during his meals.</p> <p>2. Observation on 7/15/2010 at approximately 5:05 p.m. revealed Resident #3 was lying in her bed on her back and slightly to her right. A later observation at approximately 5:25 p.m. revealed she was transported from her bed to her wheelchair and transferred to a large beanbag in the living room.</p> <p>Record review on 7/16/2010 at approximately 6:35 p.m. revealed Resident #3 ' s 10/26/2009 Physical Therapy assessment identified she ' s diagnosed with having spastic quadriplegia, dislocated left hip and cerebral palsy. The assessment goes to further recommend the following:</p> <p>" DO NOT position [Resident #3] on her back with her lower trunk and legs rotated to the right.</p>	I 430	<p>All staff were trained on client #1's mealtime protocol with emphasis on mealtime adaptive equipment on 7-28-10</p> <p>Staff were retrained again on 8-16-10</p> <p>Refer to attachment #2</p> <p>Currently client #1 consumes his foods using a teaspoon.</p> <p>In the future, the facility management will ensure that all individuals use the mealtime adaptive equipment as prescribed by the consultant.</p> <p>All staff were inserviced by the PT on client #3 repositioning on 7-29-10</p> <p>Refer tot attachment #3</p> <p>As per PT training on 7-29-10, staff must support client #3 with pillows, and align her body.</p> <p>In the future, the house management will ensure the consistent implementation of client #3 repositioning as recommended by the Physical Therapist.</p> <p>All staff were inserviced by the PT on client #3 repositioning on 7-29-10</p> <p>Refer tot attachment #3</p> <p>As per PT training on 7-29-10, staff must support client #3 with pillows, and align her body.</p> <p>In the future, the house management will ensure the consistent implementation of client #3 repositioning as recommended by the Physical Therapist.</p>	

