

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from August 17, 2011 through August 18, 2011. A sample of two clients was selected from a population of two females with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.</p>	W 000	<p><i>Received</i> <i>Sept. 12, 2011</i> Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 159	<p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the qualified intellectual disabilities professional (QIDP), for one of two sampled clients. (Client #1)</p> <p>The finding includes:</p> <p>1. Cross refer to W369. The facility's QIDP failed to coordinate Client #1's Activity Schedule with the medication administration nurse.</p> <p>On August 18, 2011, at 12:10 a.m., record review</p>	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>John Markin</i>	TITLE  <i>Adm. Asst</i>	(X5) DATE  <i>9/9/11</i>
---	-------------------------------	--------------------------------

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.

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) COMPLETION DATE
W 159	<p>Continued From page 1</p> <p>revealed that the Client #1's activity schedule, documented that she should eat her breakfast at 7:20 a.m. and then be administered her morning medications at 7:45 a.m. At the time of the survey, the client's activity schedule had not been modified to ensure that she received the Lopid 600 mg. 30 minutes before breakfast as prescribed to reduce her serum cholesterol.</p> <p>2. The QIDP failed to coordinate services to ensure that foods required to accurately implement Client #1's therapeutic diet were available.</p> <p>Observation of Client #1 at her day program on August 17, 2011, at 11:35 a.m., revealed her lunch included a peanut butter and jelly sandwich (bite-size) and 16 ounces of a red colored beverage, in addition to the other foods. The client was observed to consume the entire meal. Dinner observations on the same day at 5:23 p.m., revealed the client's beverages included 1 cup of apple juice and water. Further observation of the client during these times revealed she was significantly overweight for her height.</p> <p>Interview with staff at the day program and the group home at the aforementioned times revealed that Client #1 was prescribed a 1500 calorie diet to help her lose weight. On the same day at 6:10 p.m., interview with the direct care staff concerning the red beverage served to Client #1 for lunch revealed that it was probably juice, because no diet beverage was available. On August 18, 2011, at 12:20 p.m., interview with the home manager concerning the client's meals received on August 17, 2011, revealed the red colored beverage may have been cranberry juice,</p>	W 159	<p><b>W 159.1</b></p> <ul style="list-style-type: none"> <li>- Client #1's activity schedule will be modified to reflect administration of medication (Lopid) 30 minutes before meal at all times. A memo will be sent to the nurses and Direct Care Staff to emphasize the need to adhere to such order.</li> <li>- The Medication Administration Records (MARs) of other individuals in the facility will be reviewed to ensure that any individual affected by such deficiency is corrected as specified above.</li> <li>- The facility's House Manager will conduct monthly monitoring to ensure that nurses or Trained Medication Employees (TMEs) are adhering to physician's order pertaining to the time medications are to be administered.</li> </ul>	09/30/11

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 159** Continued From page 2  
used as a substitute for a diet beverage. Upon request by the surveyor, the HM showed the surveyor a jar of regular jelly, which she stated was used with the peanut butter to prepare a sandwiches for the client.

On August 17, 2011 at 3:05 p.m., review of Client #1's physician's orders dated August 1, 2011 revealed she was prescribed a 1500 calorie, low cholesterol, low sodium, chopped food diet. On the same day, at 6:15 p.m., review of the menu revealed the following should be provided for the client to ensure she did not exceed 1500 calories/day:

a. diet jelly instead of regular jelly  
b. 1/2 cup diet beverage for lunch and dinner

At the time of the survey, the facility failed to ensure that the appropriate foods were available to be served to the client.

**W 159**

**W 159.2**

- The facility's nutritionist has been requested to develop a list of foods that will meet Client #1's dietary needs. This will also be done for other individuals in the facility
- The House Manager will conduct weekly audits to ensure that appropriate foods for Client #1 and #2 are available as specified on the weekly menu
- Staff will be trained on dietary needs of Client #1 and #2
- Once weekly during varying shifts, the House Manager will monitor staff during meal time to ensure that dietary orders are adhered to as specified.

**09/30/11**

**W 189** 483.430(e)(1) STAFF TRAINING PROGRAM

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure that each staff was effectively trained to meet the needs of two of two clients in the sample. (Clients #1 and #2)

The findings include:

Cross refer to W474. The facility failed to ensure

**W 189**

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 189 Continued From page 3  
that Client #1's and #2's food served was served in a form consistent with their identified developmental needs.

W 189

W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN

W 247

The individual program plan must include opportunities for client choice and self-management.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure clients were provided with opportunities for choice and self-management during snack time, for one of two clients included in the sample. (Client #2)

The finding includes:

The facility failed to ensure Client #2 was afforded opportunities for choice and self-management during snack time, as evidenced below:

On August 17, 2011, at approximately 11:10 a.m., observations conducted at the day program revealed Client #2 had a small body stature. On August 17, 2011, at approximately 4:00 p.m., Client #2 was given chocolate pudding in a small glass bowl during snack time. The direct care staff attempted to feed Client #2 after she refused to eat the pudding independently. When staff brought the pudding close to the client's mouth, she was observed to shake her head (no). There were no other snacks offered or given by the direct care staff. At approximately 4:30 p.m. observation of the kitchen revealed there were several other snacks available (i.e. apples,

W 247

- The facility's Qualified Intellectual Disabilities Professional (QIDP) will in-service all staff of the facility on the subject of provision of choice during meals and other habilitation needs

- Once weekly during varying shifts, the QIDP will monitor staff during meals to ensure that Client #1 and #2 are provided choices

09/30/11

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>		
(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 247	Continued From page 4 bananas, oranges, etc.).  Interview with the direct care staff on August 17, 2011, at 5:34 p.m., confirmed that there were several other snacks available. Further interview revealed that he should have presented all available snacks to the client during snack time. On August 18, 2011, at 9:10 a.m., review of the current physician's orders (POs) dated July 27, 2011, revealed an order for Client #2 to receive three (3) snacks a day.	W 247			
W 325	<b>482.460(a)(3)(iii) PHYSICIAN SERVICES</b>  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of two clients included in the sample. (Client #2)  The finding includes:  The facility's nursing service failed to ensure Client #2's routine laboratory studies (Depakote) were obtained as recommended by the primary care physician, as evidenced below:  On August 17, 2011, at approximately 7:50 a.m., observation of the morning medication administration pass revealed that Client #2 was	W 325			

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 325** Continued From page 5  
administered Divalproex Sodium Dr (Depakote) 250 mg by mouth. Interview with licensed practical nurse (LPN) revealed that the depakote was prescribed for depression.

Review of Client #2's medical records on August 17, 2011, at approximately 1:45 p.m., revealed a physician's order (PO's) dated August 2010. According to the PO's, Client #2's depakote levels were to be monitored every three months. Subsequent review of her medical records revealed there were no laboratory studies done until February 26, 2011, for the depakote (approximately seven (7) months after the August 2010 POs).

**W 325**

**W 325**

- A tracking system will be put in place to capture when labs are to be done
- The facility's Registered Nurse (RN) will on a monthly basis audit all medical records to ensure that physician orders are adhered to as specified

**09/30/11**

Interview with the facility's registered nurse (RN) and further record review on August 17, 2011, at 3:45 p.m., confirmed that laboratory studies for depakote were not completed as prescribed.

**W 331** 483.460(c) NURSING SERVICES

**W 331**

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 review, the facility failed to ensure nursing services were provided in accordance with the needs of, one of two clients included in the sample. (Client #2)

The finding includes:

Cross refer to W325. The facility's nursing staff failed to ensure routine laboratory testing as determined necessary by the physician for Client

**W 331**

- Please see W325

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/18/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COMP CARE II	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019
--	--

(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 369 Continued From page 7  
to ensure that the client received the medication at the prescribed time.

W 440: 483.470(i)(1) EVACUATION DRILLS

The facility must hold evacuation drills at least quarterly for each shift of personnel.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for two of two clients residing in the facility. (Clients #1 and #2)

The finding includes:

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On August 17, 2011 at 9:24 a.m., interview with the house manager (HM) revealed that there were two designated shifts (3:00 PM - 10:00 PM and 10:00 AM - 8:30 PM Monday thru Friday. Further interview revealed that there were two designated shifts (10:00 AM - 10:00 PM and 10:00 PM - 10:00 AM) for the weekend (Saturday/Sunday).

Review of the facility's fire drill log records on August 17, 2011, beginning at 9:30 a.m., revealed that no drills were held during the weekend second shift (10:00 PM - 10:00 AM) from April 2011 through June 2011. On August 17, 2011, 10:37 a.m., the qualified intellectual disabilities professional (QIDP) and HM confirmed that fire drills were not conducted on the weekend second shift from April 2011 through

W 369

W 440: W 440

- The facility's fire drill schedule will be revised to ensure that simulated fire drills are conducted at least four (4) times a year for each shift.

- All staff will be trained on conducting fire drills with emphasis on frequency drills are to be conducted. This is to ensure that staff are competent in conducting fire drills across shifts

- Once monthly, the facility's House Manager will audit the fire drill records to ensure compliance with Tag W440.

09/30/11

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>		
(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 440	Continued From page 8 June 2011.	W 440			
W 441	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills under varied conditions.  This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for two of two clients residing in the facility. (Clients #1 and #2)  The finding includes:  On August 17, 2011, beginning at 9:30 a.m., review of the facility's fire drill records revealed that all available fire drills reviewed were conducted utilizing the front, back, and side door exits. Interview with the house manager (HM) on August 17, 2011, at 9:24 a.m., revealed that the facility had four methods of egress (front, back, side, and basement door exits). Further review of the fire drill records revealed that the basement door exit had not been used since September 2010.  On August 17, 2011, at 10:37 a.m., the HM and the QIDP confirmed that the basement door exit was not utilized during the past year. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441	<div style="border: 1px solid black; padding: 5px;"> <p>W 441</p> <ul style="list-style-type: none"> <li>- The facility's fire drill schedule will be revised to capture all methods of egress including the basement door.</li> <li>- All staff will be trained on conducting fire drills to ensure that all methods of egress are utilized during drills. During the in-service, emphasis will be placed on utilization of the basement door as part of the methods of egress.</li> <li>- Once monthly, the facility's House Manager will audit the fire drill records to ensure that staff are efficiently utilizing the basement door and other methods of egress.</li> </ul> </div>		
W 474	483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.	W 474		09/30/11	

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 474** Continued From page 9

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility failed to ensure that clients' received food in a form consistent with their developmental levels, for two of two clients included in the sample. (Clients #1 and #2)

The findings include:

1. The facility failed to ensure that Client #2's food was served in a form consistent with her identified developmental need.

On August 17, 2011, at approximately 12:02 p.m., observations conducted at the day program revealed, Client #2 was served a ground texture diet for lunch that consisted of carrots, mash potatoes, and Salisbury steak and gravy. Later that evening at approximately 5:15 p.m., observations of the dinner meal revealed Client #2's BBQ steak, rice, brussels sprouts, and a slice of bread was served bite sized. At 5:38 p.m., the evening licensed practical nurse (LPN), house manager (HM), and the direct care staff all observed and acknowledged that Client #2's dinner was not finely chopped to the consistency of hamburger.

Interview with the HM on August 17, 2011, at approximately 5:30 p.m., revealed that Client #2's food was not served in the right texture as prescribed. Further interview with the HM revealed that all staff had received training from the nutritionist on Client #2's diet texture.

On August 18, 2011, at approximately 9:10 a.m., review of Client #2's current physician's orders (POs) dated July 2011 revealed the client was

**W 474**

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 474	<p>Continued From page 10</p> <p>prescribed a regular finely chopped diet. Review of Client #2's Mealtime Protocol dated July 2011 on the same day at approximately 1:10 p.m., revealed that the client's meats and other foods should be finely chopped (foods are cut into small pieces about the size of hamburger). Further review of the protocol revealed that the client had a diagnosis of severe oral pharyngeal phase dysphasia (swallow dysfunction) which placed her at risk for aspiration.</p> <p>Note: It should be noted that review of the in service training records on August 18, 2011, at approximately 10:00 a.m., revealed that all staff had received training on Client #2's diet type, diet texture, and mealtime protocol on April 7, 2011.</p> <p>2. The facility failed to ensure that Client #1's food was served in a form consistent with her identified developmental need, as evidenced below:</p> <p>Observation of Client #1 at her day program on August 17, 2011, at 11:35 a.m. revealed she appeared to be edentulous as she ate her bag lunch. The client was observed removing bite size pieces of peanut butter and jelly sandwich from a sandwich bag and eating them. After eating the sandwich, the client was observed to eat 10 saltine crackers sandwiches (crackers filled with sliced cheese). Interview with the day program staff supervising the client revealed that she always brought her lunch from home and ate everything.</p> <p>Further observation of Client #1 on the same day at 5:23 p.m., during dinner revealed she was served barbecue beef which was cut into pieces measuring approximately 3/4 to 1 inch in</p>	W 474	<p>W 473: 1 &amp; 2</p> <ul style="list-style-type: none"> <li>- The facility's nutritionist will re-train staff on Client #1's and Client#2's diet textures</li> <li>- Staff training will be done quarterly to ensure competency in adhering to Client #1's and Client #2's diet.</li> <li>- On a weekly for the next 90 days, the facility's House Manager will monitor staff during meal time to ensure that diet orders are adhered to as specified.</li> </ul>	09/30/11
-------	--	-------	--	----------

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/18/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COMP CARE II	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019
--	--

(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 474	<p>Continued From page 11</p> <p>diameter. The client proceeded to place some of the pieces of the meat onto a slice of bread, ate them in a sandwich, then ate the remaining pieces of meat. During the meal, a mealtime protocol was observed on the dining table, near the client's plate. Interview with the staff during this time revealed the client was prescribed a chopped diet and that food should be cut approximately the size of cheerios.</p> <p>On August 17, 2011, at approximately 3:05 p.m., review of Client #1's physician's orders dated August 2011 revealed the client was prescribed a 1500 calorie, low cholesterol, low sodium, chopped diet. Review of Client #1's Mealtime Protocol dated July 2011 on August 18, 2011 at 12:42 p.m. revealed that the client's food should be chopped. The third quarterly nutrition review dated June 7, 2011, revealed that the client required chopped foods at all meals to eliminate risk of choking, due to her history of eating rapidly. The facility failed to ensure that Client #1 receive each food textured in accordance with her assessed developmental need.</p>	W 474		
-------	---	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>	
(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)
	<p><b>1000 INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from August 17, 2011 through August 18, 2011. A sample of two residents was selected from a population of two males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations and interviews with staff in the resident and at two day programs, as well as a review of resident and administrative records, including incident/investigation reports.</p> <p><b>1042 3502.2(b) MEAL SERVICE / DINING AREAS</b></p> <p>Modified diets shall be as follows:</p> <p>(b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that modified diets were served as prescribed, for two of two residents included in the sample. (Residents #1 and #2)</p> <p>The finding includes:</p> <p>The GHPID failed to ensure that Resident #1 and #2 received food in a form consistent with her prescribed dietary needs, as evidenced below:</p> <p>1. On August 17, 2011, at approximately 12:02 p.m., observations conducted at the day program revealed, Resident #2 was served a ground texture diet for lunch that consisted of carrots,</p>	<p><b>1000</b></p> <p><b>1042</b></p>	

(X5) COMPLETE DATE

(X6) DATE  
**9/9/11**

TITLE  
*Adm. Asst*

*Johna Marklin*

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0000

DOVF11

If continuation sheet 1 of 8

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>	
(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)
I 042	<p>Continued From page 1</p> <p>mash potatoes, and Salisbury steak and gravy. Later that evening at approximately 5:15 p.m., observations of the dinner meal revealed Resident #2's BBQ steak, rice, Brussels sprouts, and a slice of bread was served in a bite sized texture diet. At 5:38 p.m., the evening licensed practical nurse (LPN), house manager (HM), and the direct care staff all observed and acknowledged that Resident #2's dinner was not finely chopped to the consistency of hamburger. The HM stated that Resident #2's food was not served in the right texture as prescribed.</p> <p>On August 18, 2011, at approximately 9:10 a.m., review of Resident #2's current physician's orders (POs) dated July 2011 the resident was prescribed a regular finely chopped diet. Review of Resident #2's Mealtime Protocol dated July 2011 on the same day at approximately 1:10 p.m., revealed that the resident's meats and other foods texture should be finely chopped (foods are cut into small pieces about the size of hamburger). Further review of the protocol revealed that the resident had a diagnosis of severe oral pharyngeal phase dysphasia (swallow dysfunction) which placed her at risk for aspiration.</p> <p>Note: It should be noted that review of the in service training records on August 18, 2011, at approximately 10:00 a.m., revealed that all staff had received training on Resident #2's diet type, diet texture, and mealtime protocol on April 7, 2011.</p> <p>2. Observation of Resident #1 at her day program on August 17, 2011, at 11:35 a.m. revealed she appeared to be edentulous as she ate her bag lunch. The resident was observed removing bite size pieces of peanut butter and jelly sandwich</p>	I 042	<p>I 042: 1 &amp; 2</p> <ul style="list-style-type: none"> <li>- The facility's nutritionist will re-train staff on Client #1's and Client#2's diet textures</li> <li>- Staff training will be done quarterly to ensure competency in adhering to Client #1's and Client #2's diet.</li> <li>- On a weekly for the next 90 days, the facility's House Manager will monitor staff during meal time to ensure that diet orders are adhered to as specified.</li> </ul>
			<p>(X5) COMPLETE DATE  <b>09/30/11</b></p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/18/2011
NAME OF PROVIDER OR SUPPLIER  COMP CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		
(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 042	<p>Continued From page 2</p> <p>from a sandwich bag and eating them. After eating the sandwich, the resident was observed to eat 10 saltine crackers sandwiches (crackers filled with sliced cheese). Interview with the day program staff supervising the resident revealed that she always brought her lunch from home and ate everything.</p> <p>Further observation of Resident #1 on the same day at 5:23 p.m., during dinner revealed she was served barbecue beef which was cut into pieces measuring approximately 3/4 to 1 inch in diameter. The resident proceeded to place some of the pieces of the meat onto a slice of bread, ate them in a sandwich, then ate the remaining pieces of meat. During the meal, a mealtime protocol was observed on the dining table, near the resident's plate. Interview with the staff during this time revealed the resident was prescribed a chopped diet and that food should be cut approximately the size of cheerios.</p> <p>On August 17, 2011, at approximately 3:05 p.m., review of Resident #1's physician's orders dated August 2011 revealed the resident was was prescribed a 1500 calorie, low cholesterol, low sodium, chopped diet. Review of Resident #1's Mealtime Protocol dated July 2011 on August 18, 2011 at 12:42 p.m. revealed that the resident's food should be chopped. The third quarterly nutrition review dated June 7, 2011, revealed that the resident required chopped foods at all meals to eliminate risk of choking, due to her history of eating rapidly. The facility failed to ensure that Resident #1 receive each food textured in accordance with her assessed developmental need.</p>	I 042		
I 090	3504.1 HOUSEKEEPING	I 090		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 090	<p>Continued From page 3</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of two of two residents in the facility (Residents #1 and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On August 18, 2011 at 9:47 a.m., observation of the one of two trash cans located adjacent to the basement door of the GHPID revealed multiple torn area on the sides, which created a potential entrance for rodents and other pests.</li> <li>2. A heavy accumulation of rust was observed on the painted surface of the porch located at the rear of the GHPID.</li> </ol> <p>Interview the residential director acknowledged the aforementioned findings.</p>	I 090	<p><b>I 090.1</b></p> <ul style="list-style-type: none"> <li>- The trash can has been replaced.</li> <li>- The porch has been painted</li> <li>- The facility's maintenance team and the House Manager will on a monthly basis conduct internal and external audits to ensure compliance with Tag I 090</li> </ul>	09/08/11
I 135 3505.5 FIRE SAFETY	<p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group</p>	I 135		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>		
(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 135	<p>Continued From page 4</p> <p>home for intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for two of two residents in the facility. (Residents #1 and #2)</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On August 17, 2011 at 9:24 a.m., interview with the house manager (HM) revealed that there were two designated shifts (3:00 PM - 10:00 PM and 10:00 AM - 8:30 PM Monday thru Friday. Further interview revealed that there were two designated shifts (10:00 AM - 10:00 PM and 10:00 PM - 10:00 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on August 17, 2011, beginning at 9:30 a.m., revealed that no drills were held during the weekend second shift (10:00 PM - 10:00 AM) from April 2011 through June 2011. On August 17, 2011, 10:37 a.m., the qualified intellectual disabilities professional (QIDP) and HM confirmed that fire drills were not conducted on the weekend second shift from April 2011 through June 2011.</p>	I 135	<p>I 135</p> <ul style="list-style-type: none"> <li>- The facility's fire drill schedule will be revised to ensure that simulated fire drills are conducted at least four (4) times a year for each shift.</li> <li>- All staff will be trained on conducting fire drills with emphasis on frequency drills are to be conducted. This is to ensure that staff are competent in conducting fire drills across shifts</li> <li>- Once monthly, the facility's House Manager will audit the fire drill records to ensure compliance with Tag I 135.</li> </ul>	09/30/11
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record</p>	I 180		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	I 180.1  - Client #1's activity schedule will be modified to reflect administration of medication (Lopid) 30 minutes before meal at all times. A memo will be sent to the nurses and Direct Care Staff to emphasize the need to adhere to such order.  - The Medication Administration Records (MARs) of other individuals in the facility will be reviewed to ensure that any individual affected by such deficiency is corrected as specified above.  - The facility's House Manager will conduct monthly monitoring to ensure that nurses or Trained Medication Employees (TMEs) are adhering to physician's order pertaining to the time medications are to be administered.	(X5) COMPLETE DATE
--------------------	--	---------------	--	--------------------

I 180	<p>Continued From page 5</p> <p>review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that each resident's active treatment program was coordinated, integrated and monitored by the qualified intellectual disabilities professional (QIDP), for one of residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>1. Cross refer to Citation I0401. The GHPID's QIDP failed to coordinate Resident #1's Activity Schedule with the medication administration nurse.</p> <p>On August 18, 2011, at 12:10 a.m., review revealed that the Resident #1's activity schedule, documented that she should eat her breakfast at 7:20 a.m. and then be administered her morning medications at 7:45 a.m. At the time of the survey, the client's activity schedule had not been modified to ensure that she received Lopid 600 mg. 30 minutes before breakfast, as prescribed to reduce her serum cholesterol.</p> <p>2. Cross refer to Federal Deficiency Report - Citation W159.2. The GHPID's QIDP failed to coordinate services to ensure that foods required to accurately implement Client #1's therapeutic diet were available.</p>	I 180
-------	--	-------

I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p>	I 401
-------	---	-------

<p>I 180.2</p> <p>Please cross refer to response of Federal Deficiency Citation W 159.2</p>
---

<p>09/30/11</p>
-----------------

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>	
(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)
I 401	<p>Continued From page 6</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included 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 for two of two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. The GHPID's nursing service failed to ensure Resident #2's routine laboratory studies (Depakote) were obtained as recommended by the primary care physician, as evidenced below:</p> <p>On August 17, 2011, at approximately 7:50 a.m., observation of the morning medication administration pass revealed that Resident #2 was administered Divalproex Sodium Dr (Depakote) 250 mg by mouth. Interview with licensed practical nurse (LPN) revealed that the depakote was prescribed for depression.</p> <p>Review of Resident #2's medical records on August 17, 2011, at approximately 1:45 p.m., revealed a physician's order (PO's) dated August 2010. According to the PO's, Resident #2's depakote levels were to be monitored every three months. Subsequent review of her medical records revealed there were no laboratory studies done until February 26, 2011, for the depakote (approximately seven (7) months after the August 2010 POs).</p> <p>Interview with the facility's registered nurse (RN)</p>	I 401	<p>I 401.1</p> <ul style="list-style-type: none"> <li>- A tracking system will be put in place to capture when labs are to be done</li> <li>- The facility's Registered Nurse (RN) will on a monthly basis audit all medical records to ensure that physician orders are adhered to as specified</li> </ul>
			<b>09/30/11</b>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>COMP CARE II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 NEWTON STREET NE WASHINGTON, DC 20019</b>
---	--

(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 401	<p>Continued From page 7</p> <p>and further record review on August 17, 2011, at 3:45 p.m., confirmed that laboratory studies for depakote were not completed as prescribed.</p> <p>2. The GHPID's nursing services failed to ensure that Resident #1 received a medication at the prescribed time.</p> <p>On August 17, 2011, at 7:15 a.m., the direct care staff informed the surveyor that the residents had just finished eating breakfast. The dining table was observed to have already been completely cleared. At 7:35 a.m., the LPN arrived to administer the residents their morning medications. Resident #1 was observed to receive Lopid 600 mg by mouth at 7:45 a.m. During the aforementioned medication administration, the LPN stated that the Lopid was prescribed to lower the resident's serum cholesterol.</p> <p>On August 17, 2011, at 2:15 p.m., the review of a physician's telephone order dated August 2, 2011, revealed that it stated to "Restart Lopid 600 mg thirty (30) minutes before meal.</p> <p>On August 17, 2011, at approximately 5:30 p.m., the LPN acknowledged that physician's order prescribed that Resident #1 be administered the Lopid 600 mg, 30 minutes before her meal at all times. At the time of the survey, the GHPID failed to ensure that the resident received the medication at the prescribed time.</p>	I 401	<p>I 401.2</p> <ul style="list-style-type: none"> <li>- Client #1's activity schedule will be modified to reflect administration of medication (Lopid) 30 minutes before meal at all times. A memo will be sent to the nurses and Direct Care Staff to emphasize the need to adhere to such order.</li> <li>- The Medication Administration Records (MARs) of other individuals in the facility will be reviewed to ensure that any individual affected by such deficiency is corrected as specified above.</li> <li>- The facility's House Manager will conduct monthly monitoring to ensure that nurses or Trained Medication Employees (TMEs) are adhering to physician's order pertaining to the time medications are to be administered.</li> </ul>	09/30/11
-------	--	-------	--	----------