

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

PRINTED: 09/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/16/2010	
NAME OF PROVIDER OR SUPPLIER  MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		
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W 000	INITIAL COMMENTS  A recertification survey was conducted from September 14, 2010, through September 16, 2010 utilizing the fundamental survey process. A random sampling of two clients was selected from a population of four females with various levels of mental retardation and disabilities.  The findings of the survey were based on observations at the group home and two day programs, interviews with clients, staff, and the review of clinical and administrative records, including incident reports.	W 000	<p style="text-align: center;"><b>GOVERNMENT OF THE DISTRICT OF COLUMBIA</b> DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002  10-8-10</p>		
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 implement its policies to ensure the health and safety for two of four clients residing in the facility. (Clients #1 and #3)  The finding includes:  [Cross-refer to W154.] The facility failed to implement its policy for thoroughly investigating all injuries of unknown origin for two of four clients residing in the facility.	W 149		W149 Ensure the health and safety for two of four clients residing in the facility. (Client #1 and #3)  The QDDP in conjunction with the delegating RN will investigate all incidents of unknown origin and incidents that occur outside the residence. The findings will be documented in a written report/documentation per agency policy. Director of Programs and Quality Assurance will perform quarterly QA to ensure ongoing compliance.	10-1-10- Ongoing
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.	W 154			

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

TITLE

(X8) DATE

*Ken McCallister*

*Director Health Services*

*10-7-10*

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 154	Continued From page 1  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin for two of four clients residing in the facility. (Clients #1 and #3)  The findings include:  On September 14 and 15, 2010, review of the facility's unusual incidents and investigations revealed the following:  a. On August 17, 2010, Client #3 was assisted by staff to the bathroom due to an accident. Staff went to get a change of clothing while leaving the client in the bathroom. Upon arrival back to the bathroom, staff noticed some bleeding on the bottom of Client #3's foot. First aid was applied. Interview with the facility's Registered Nurse (RN) on September 15, 2010, at approximately 6:06 p.m., revealed Client #3 was assessed as having a small superficial scratch on the bottom of her foot. When asked, the RN stated that the potential source of the injury had not been investigated to determine its cause.  b. On August 27, 2010, while in the front lobby (at the day program) waiting to leave, Client #1 was scratched by another individual who was said to be having a behavior. Continued review of the incident report revealed the client refused to see the nurse. A telephone interview conducted with the Residential Director/Incident Management Coordinator on September 16, 2010, at approximately 3:00 p.m., revealed that the incident had not be investigated to determined what actually happened while at the day program.	W 154	<b>W154</b> Ensure the health and safety for two of four clients residing in the facility. (Client #1 and #3)  a) Reference response to W149  b) Reference response to W149	Reference W149

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W 154	Continued From page 2 Review of the facility's incident management policy (IMP) on September 16, 2010, at approximately 2:20 p.m., revealed that when incidents/injuries of unknown origin (major/minor) are discovered, investigations are conducted to try to ascertain the origin. These incidents are investigated as serious reportable incidents. Further review of the IMP revealed that in order to ensure the health/safety of clients served, incidents occurring outside the facility must be reported regardless of where it occurs. It is crucial that the day and residential programs communicate on any incident.  At the time of the survey, there was no documented evidence that the aforementioned incidents had been investigated.	W 154		
W 322	483.460(a)(3) PHYSICIAN SERVICES  The facility must provide or obtain preventive and general medical care.  This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure timely preventive health services, for one of the two clients in the sample. (Client #2)  The findings include:  1. On September 14, 2010 at 2:35 p.m., the review of an unusual incident report dated June 2, 2010, revealed that Client #2 was taken to the emergency room (ER) due to respiratory distress.  Interview with the residential director (RD) on	W 322		

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W 322	<p>Continued From page 3</p> <p>September 15, 2010 at 9:02 a.m., revealed the ER visit was initiated as a result of the client's congestion during an assessment by the primary care physician (PCP) on June 2, 2010. The RD stated that the PCP recommended that Client #2 be evaluated at the ER with a chest Xray to rule out pneumonia.</p> <p>On September 15, 2010 at 9:05 a.m., review of the ER discharge summary dated June 3, 2010 revealed a primary diagnosis of "Bronchitis - acute, cough", and that Client #2 was recommended to have follow-up at the health center in 1- 2 days after the ER discharge "without fail". Interview with the registered nurse (RN) and the review of records on September 15, 2010 at 9:22 a.m. revealed the client had a post ER assessment by the PCP on June 10, 2010. At the time of the survey, there was no evidence the client had received timely follow-up as recommended by the hospital ER.</p> <p>2. The facility failed to ensure that Client #2 received recommended pulmonary follow-up, as evidenced below.</p> <p>Record review on September 15, 2010 at 9:35 a.m., revealed Client #2 had a chest x-ray on June 3, 2010, as recommended by the PCP during an emergency room visit on June 2, 2010. The chest xray report, revealed an impression of, "Right lower lobe pneumonia super imposed upon extensive lung disease, especially on the left. The xray report recommended additional studies for more adequate imaging.</p> <p>Interview with the primary RN on September 15, 2010 at 9:52 a.m. revealed that the xray results (dated June 3, 2010) were provided directly to the</p>	W 322	<p>1. All post ER recommendations will be completed and individuals will be evaluated within the recommended timeframe. Additionally, if the primary care physician is unable to see the individual at home within the time frame recommended, arrangements will be made to have the individual seen at the PCP's out-patient clinic. The delegating RN will promptly communicate any delay or anticipated delay in securing follow-up evaluations to the Director of Health Services.</p> <p>2. The additional studies suggested by the radiologist were not recommended by the PCP due to Client #1's medical appointment anxiety and positive result to implemented treatments. Pulmonary follow-up is scheduled for October 27, 2010. The delegating nurse will review all recommendations and in collaboration with the interdisciplinary team facilitate prompt follow-up. The delegating RN will promptly communicate any delay or anticipated delay in securing follow-up evaluations to the Director of Health Services.</p>	10.1.10  10.27.10

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W 322	Continued From page 4 PCP by the hospital. The PCP prescribed antibiotics to treat the pneumonia, which were administered. The RN indicated that the client had a post ER visit follow-up visit with the PCP on June 10, 2010.  Record review on September 15, 2010 at 9:55 a.m. confirmed the discussion with the RN. On September 15, 2010 at 10:15 a.m., review of the PCP's consultation report dated June 10, 2010, however, revealed "Asthmatic Bronchitis, improved." The PCP also recommended that Client #2 have a pulmonary consultation.  At the time of the survey, however, there was no evidence that the additional studies for more adequate imaging recommended by the radiologist, or the pulmonary consultation recommended by the PCP had been conducted.	W 322		
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 two of four clients residing in the facility. (Clients #2 and #4)  The findings include:  1. [Cross-refer to W368 and W369 ] The facility's nursing staff failed to ensure that all drugs were administered in compliance with the physician's orders.	W 331	1. The medication time for Client #4 was discussed with the PCP and the administration time has been changed to "evening." Medication regimens have been reviewed to ensure medication timings are appropriate both therapeutically and in terms safe administration by a nurse or TME. Staff will receive additional training on safe administration of medications, to include timeliness of administration and medication errors. Periodic medication pass observations will be conducted by the Delegating RN to ensure compliance and provide technical assistance.	09.16.10  10.15.10



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W 368	Continued From page 6  2. Observation of the medication administration on September 16, 2010, at approximately 5:55 p.m., revealed LPN #1 administered Client #4, Zetta U-D 10 mg. by mouth. Further observation revealed that Client #4 was served dinner at approximately 6:45 p.m..  Review of Client # 4's POS dated September 2010, on September 16, 2010, at approximately 6:56 p.m., revealed an order to administer Zetta U-D 10 mg. by mouth every day with dinner.  During a face-to-face interview with LPN #1 and the RN Supervisor on September 16, 2010, at approximately 7:01 p.m., it was acknowledged Client #4 was not administered Zetta U-D 10 mg. by mouth with dinner.	W 368	2. The Staff will receive additional training on safe administration of medications, to include timeliness of administration and medication errors. Periodic medication pass observations will be conducted by the Delegating RN to ensure compliance and provide technical assistance.	10-15-10  Ongoing
W 369	483.460(k)(2) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of four clients in the facility. (Client # 4)  The finding includes:  [Cross refer to W368.] The facility failed to ensure that medications prescribed for Client #4 were administered at the prescribed time.  Observation of the medication administration on	W 369	Reference response to W322	

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W 369	Continued From page 7 September 16, 2010, at approximately 5:55 p.m., revealed the Licensed Practical Nurse #1 (LPN #1) did not administer Client #4's Lipitor 20 mg. and Zetta U-D 10 mg. at the time prescribed by the primary care physician.	W 369			
W 440	<b>483.470(i)(1) EVACUATION DRILLS</b>  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 the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on one of two shifts of drills reviewed. (2:30 PM to 11:30 PM shift)  The finding includes:  On September 15, 2010, at 12:27 p.m., interview with the house manager (HM) revealed the facility had two shifts of direct care personnel. The shifts were identified as weekdays/weekend 2:30 PM - 11:30 PM and 11 PM - 9 AM.  Review of the fire drill reports from October 2009 to September 2010 was conducted on September 15, 2010, at 12:30 p.m. Further review of the fire drill reports from October 2009 to March 2010 revealed there were no fire drills conducted during the 2:30 PM to 11:30 PM shift during the week. Interview with the HM on the same day at approximately 1:35 p.m., acknowledged that no fire drills were conducted during the aforementioned shifts.	W 440	<b>W440</b> Conduct evacuation drills at least quarterly for each shift of personnel.  Staff will receive in-service training on conducting fire drills in compliance with regulatory requirements. The QDDP in conjunction with the Program Manager will review fire drill records weekly to ensure regulatory compliance. In cases of noncompliance, a correction will be made and documented.	10.15.10 - Ongoing	

Health Regulation Administration

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I 000	INITIAL COMMENTS  A licensure survey was conducted from September 14, 2010, through September 16, 2010. A random sampling of two residents was selected from a population of four females with various levels of mental retardation and disabilities.  The findings of the survey were based on observations at the group home for mental retarded persons (GHMRP) and two day programs, interviews with residents, staff, and the review of clinical and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation, interview, record review, the Group Home for Mentally Retarded Persons failed to maintain the physical environment.  The findings include:  During the environmental inspection on September 15, 2010, beginning at approximately 2:35 p.m., the following concerns were identified:  1. On each day of the survey, the area rug on the floor of the half bathroom was observed to move when touched at the edge. On September 15, 2010 the area rug on the master bathroom was observed to also move in the aforementioned	I 090	I090 Maintain GHMRP in a safe, clean, orderly, attractive and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  1. The QDDP/Program Manager will purchase replacement rugs for half bath and master bathrooms that have non-skid backing to prevent their movement on the floor when pressure was applied. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and replacing as necessary.	10.15.10 - Ongoing

Health Regulation Administration

*Ken Monello*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Director Health Services* 10-7-10

Health Regulation Administration

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I 090	Continued From page 1  manner. Further observation of both area rugs revealed they lacked a non-skid backing to prevent their movement on the floor when pressure was applied, which may create a potential trip hazard.  Review of the GHMRP's "Simple Precautions in the Home to prevent Falls", on September 15, 2010 at 5:05 p.m. revealed, "Place slip resistant rug on the tile floor to safely get in and out of the tub."  2. Observation of the kitchen cabinet installed below the kitchen sink revealed there was an open space, approximately 1 inch wide between the doors of the cabinet. Interview with the RD revealed that the piece of wood necessary to cover the open space was removed when the cabinet was repaired, and was not replaced.  3. The wall, directly behind the top of he range, revealed it had multiple discolored areas. Closer observation of the the surface of the wall revealed it was unfinished, which prevented it from being easily cleaned to remove the discolored areas.  4. The vent cover was missing from the ceiling in the half bathroom located off the hallway. Further observation of the bathroom revealed it lack ventilation because the exhaust fan was also missing from the ceiling vent.  5. Topical medications were observed in the personal kits in which items such as tooth brush, tooth paste were stored in the bedrooms. interview with the residential director revealed that the personal kits belonged to Residents #2 and #3. This created a potential for the resident's tampering with the topical medications when in	I 090	2. The QDDP/Program Manager will have the wood below kitchen sink between the doors of the cabinet repaired/replaced. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repairing as necessary.  3. The QDDP/Program Manager will have wall behind top of the range painted to facilitate proper cleaning. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repair as necessary.  4. The QDDP/Program Manager will repair/replace exhaust fan and vent cover from the ceiling in the half bathroom. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repairing as necessary.  5. The QDDP/Program Manager will remove all topical medications from individuals' personal kits and secure in another location. The QDDP/Program Manager will monitor the residence weekly using the Environmental Compliance Form.	10.15.10 - Ongoing  10.15.10 - Ongoing  10-15-10 - Ongoing  9-17-10. - Ongoing

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1090	Continued From page 2 their bedrooms unsupervised.  6. Numerous pairs of shoes were stored directly on the floor of the closets of all four individuals, rendering them not easily accessible to the individuals, who had ambulation and/or balance deficits.  7. Splintered boards, missing boards, and the exposed ends of several nails were observed on the gate, which provided access to the back yard of the GHMRP. These presented a potential for injury, when going through the gate.  8. At the rear of the GHMRP, observation of the right side of the roof, revealed it was several inches above the gutter. On September 14, 2010, interview with the residential director revealed that a section of the bathroom wall had become soft, requiring the wall and tiles to be replaced. On September 15, 2010, observation of the bathroom in which the damage had occurred, revealed it was near the area of the aforementioned gutter.  9. The door to the crawl space, which was located directly below the right rear gutter was observed to be rotten and splintering, creating a potential for dampness in the crawl space.  10. A black corrugated drain pipe was observed extending from the downspout at the right rear corner of the office and across the back yard. The corrugated pipe was further observed to be approximately one foot from the end of the walkway at the exit from the bedroom of Residents #1 and #2. This created a potential trip hazard for individuals when ambulating in the back yard.	1090	6. The QDDP/Program Manager will purchase off the floor shoe racks for individuals' shoes that will provide easy access for individuals that may have ambulation and/or balance deficits. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form and replacing as necessary.  7. The QDDP/Program Manager will have rear gate repaired/replaced to prevent splintered boards, missing boards and exposed nails. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repairing as necessary.  8. The QDDP/Program Manager will have right side of the roof and gutter repaired/replaced to prevent damage to the home. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repairing as necessary.  9. The QDDP/Program Manager will repair/replace the door to the crawl space to prevent dampness in the crawl space. The QDDP/Program Manager will monitor residence weekly using the Environmental Compliance Form and repairing as necessary.  10. The QDDP/Program Manager will have the black corrugated drain pipe relocated to prevent a possible trip hazard. The QDDP/Program Manager will monitor the residence weekly using the Environmental Compliance Form.	10.15.10 - Ongoing  10.15.10 - Ongoing  11-1.10 - Ongoing  11-1.10 - Ongoing

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I 090	Continued From page 3  11. A section of the downspout at the right front corner of the GHMRP was observed to be bent. This presented a potential for water to overflow from the gutter above the front door during heavy precipitation (rain).  12. Multiple cracks were observed in the caulking around the frame of the front entrance door of the GHMRP.  13. The screw necessary to keep the hand rail attached to the toilet was missing from the left side. This permitted the left hand rail to become completely detached from the toilet when it was lifted upward.  The aforementioned concerns were acknowledged by the RD and the qualified mental retardation professional during the survey.	I 090	11. The QDDP/Program Manager will repair/replace the bent downspout at the right front corner of the home to prevent water from potential overflowing from the gutter above the door during heavy precipitation. The QDDP/Program Manager will monitor the residence weekly using the Environmental Compliance Form and repairing as necessary  12. The QDDP/Program Manager will have the multiple cracks repaired around the frame of the front entrance door of the home. The QDDP/Program Manager will monitor the residence weekly using the Environmental Compliance Form.  13. The QDDP/Program Manager will have the screws replaced on the hand rails that are attached to the toilet. The QDDP/Program Manager will monitor the residence weekly using the Environmental Compliance Form and repairing as necessary	11-1-10 - Ongoing  11-1-10 - Ongoing
I 135	<b>3505.5 FIRE SAFETY</b>  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel, on one of three shifts of drills reviewed. (2:30 PM to 11:30 PM shift)  The finding includes:  Interview with the house manager (HM) on September 15, 2010, at 12:27 p.m., revealed the GHMRP had three shifts of direct care personnel. The shifts were identified as weekdays and	I 135	<b>I135</b> Conduct evacuation drills at least quarterly for each shift of personnel.  Staff will receive in-service training on conducting fire drills in compliance with regulatory requirements. The QDDP in conjunction with the Program Manager will review fire drill records weekly to ensure regulatory compliance. In cases of noncompliance, a correction will be made and documented.	10.15.10  Ongoing  10.15.10  Ongoing

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I 135	Continued From page 4  weekends 2:30 PM - 11:30 PM, 11 PM - 9 AM, 9 AM - 11 PM, and 11 PM - 9 AM.  Review of the fire drill reports from October 2009 to September 2010 was conducted on September 15, 2010, at approximately 12:30 p.m. Further review of the fire drill reports from October 2009 to March 2010 during the 2:30 PM to 11:30 PM shift revealed no fire drills were conducted during the week. Interview with the HM on the same day at approximately 1:35 p.m., acknowledged that no fire drills were conducted during the aforementioned shifts.	I 135		
I 180	<b>3508.1 ADMINISTRATIVE SUPPORT</b>  Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.  This Statute is not met as evidenced by: Based on interview, and record review, the GHMRP failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services for one resident residing in the GHMRP. (Resident #3)  The finding includes:  The QMRP failed to coordinate services to ensure timely implementation of recommendations to address the needs of Resident #3, as evidenced below.  The review of unusual incident reports on September 15, 2010, at approximately 2:45 p.m., revealed on December 24, 2009, Resident #3 sustained a laceration to the back of her head during a fall, which required sutures. The	I 180	<b>I180</b> Ensure that the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services for residents residing in the GHMRP. (Resident #3).  The QDDP in conjunction with the delegating RN and the Director of Programs and Quality Assurance will develop and implement a checklist and timetable for all investigative reports. This checklist will assist the QDDP to coordinate, integrate and monitor services for residents. Implementation of the checklist will be monitored by the Director of Programs and Quality Assurance.	10.15.10  Ongoing

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I 180	<p>Continued From page 5</p> <p>investigation report, dated December 29, 2009, revealed a recommendation that staff receive updated training by the physical therapist (PT) on fall precautions. The investigation report further noted that the PT would be contacted to assess the resident after the incident.</p> <p>Interview with the QMRP and the registered nurse (RN) on September 15, 2010, revealed that informal training had been provided to the staff prior to this incident. Continued discussion with the QMRP, RN and RD revealed they were unable to verify the exact date of the informal training after the incident.</p> <p>Further review of the investigation report dated December 29, 2009 on September 15, 2010 at 5:15 p.m., revealed that a fall risk assessment had been done. The investigation report also stated that some staff had been previously trained. The provided training records, however, revealed no further documentation of training on fall precautions until April 8, 2010. At the time of the survey, there was no evidence staff were provided PT training timely as recommended after the resident's fall.</p> <p>On September 15, 2010 at 5:17 p.m., the record review revealed that the PT reassessment which was recommended for Resident #3 on December 29, 2009, was not conducted until April 8, 2010. Interview with the QMRP at 5:20 p.m. acknowledged that the PT reassessment was not conducted timely.</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</p>	I 401	See next page	

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I 401	<p>Continued From page 6</p> <p>developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services 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 four residents in the GHMRP. ( Residents #2 and #4)</p> <p>The findings include:</p> <p>1. Observation of the medication administration on September 16, 2010, at approximately 5:55 p.m., revealed the Licensed Practical Nurse #1 (LPN #1) administered Resident #4, Lipitor 20 mg. one tablet by mouth.</p> <p>Review of Resident # 4's physician's order sheet (POS) dated September, 2010, on September 16, 2010, at approximately 6:55 p.m., revealed an order to administer Lipitor 20 mg. one tablet by mouth at bedtime.</p> <p>During a face to face interview with LPN #1 and Registered Nurse (RN) Supervisor on September 16, 2010, at approximately 7:00 p.m., it was acknowledged Lipitor 20 mg. one tablet by mouth was administered at 5:55 p.m., in the evening and was not administered at bedtime.</p> <p>2. Observation of the medication administration on September 16, 2010, at approximately 5:55 p.m., revealed LPN #1 administered Resident #4,</p>	I 401	<p>1. The medication time for Client #4 was discussed with the PCP and the administration time has been changed to "evening." Medication regimens have been reviewed to ensure medication timings are appropriate both therapeutically and in terms safe administration by a nurse or TME. Staff will receive additional training on safe administration of medications, to include timeliness of administration and medication errors. Periodic medication pass observations will be conducted by the Delegating RN to ensure compliance and provide technical assistance.</p>	9.16.10  Ongoing

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I 401	<p>Continued From page 7</p> <p>Zetta U-D 10 mg. by mouth. Further observation revealed that Resident #4 was served dinner at approximately 6:45p.m.</p> <p>Review of Resident # 4's POS dated September 2010, on September 16, 2010, at approximately 6:56 p.m., revealed an order to administer Zetta U-D 10 mg. by mouth every day with dinner.</p> <p>During a face-to-face interview with LPN #1 and the RN Supervisor on September 16, 2010, at approximately 7:01 p.m., it was acknowledged Resident #4 was not administered Zetta U-D 10 mg. by mouth with dinner.</p> <p>3. The GHMRP failed to ensure timely preventive health services, for Resident #2.</p> <p>a. On September 14, 2010 at 2:35 p.m., the review of an unusual incident report dated June 2, 2010, revealed that Resident #2 was taken to the emergency room (ER) due to respiratory distress.</p> <p>Interview with the residential director (RD) on September 15, 2010 at 9:02 a.m., revealed the ER visit was initiated as a result of the resident's congestion during an assessment by the primary care physician (PCP) on June 2, 2010. The RD stated that the PCP recommended that Resident #2 to be evaluated at the ER with a chest Xray to rule out pneumonia.</p> <p>On September 15, 2010 at 9:05 a.m., review of the ER discharge summary dated June 3, 2010 revealed a primary diagnosis of "Bronchitis - acute, cough", and that Resident #2 was recommended to have follow-up at the health center in 1- 2 days after the ER discharge "without fail". Interview with the registered nurse</p>	I 401	<p>2. Reference response to I 401 - 1</p> <p>3a. In future, all post ER recommendations will be completed and individuals will be evaluated within the recommended timeframe. Additionally, if the primary care physician is unable to see the individual at home within the time frame recommended, arrangements will be made to have the individual seen at the PCP's out-patient clinic. The delegating RN will promptly communicate any delay or anticipated delay in secure follow-up evaluations to the Director of Health Services.</p> <p>3b. The additional studies suggested by the radiologist were not recommended by the PCP due to Client #1's medical appointment anxiety and positive result to implemented treatments. Pulmonary follow-up is scheduled for October 27, 2010. The delegating nurse will review all recommendations and in collaboration with the interdisciplinary team facilitate prompt follow-up. The delegating RN will promptly communicate any delay or anticipated delay in secure follow-up evaluations to the Director of Health Services.</p>	

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I 401	<p>Continued From page 8</p> <p>(RN) and the review of records on September 15, 2010 at 9:22 a.m. revealed the resident had a post ER assessment by the PCP on on June 10, 2010. At the time of the survey, there was no evidence the resident had received timely follow-up as recommended by the hospital ER.</p> <p>b. The GHMRP failed to ensure that Resident #2 received recommended pulmonary follow-up, as evidenced below:</p> <p>Record review on September 15, 2010 at 9:35 a.m., revealed Resident #2 had a chest x-ray on June 3, 2010, as recommended by the PCP during an emergency room visit on June 2, 2010. The chest Xray report, revealed an impression of, "Right lower lobe pneumonia super imposed upon extensive lung disease, especially on the left. The Xray report recommended additional studies for more adequate imaging.</p> <p>Interview with the primary RN on September 15, 2010 9:52 a.m. revealed that the Xray results (dated June 3, 2010) were provided directly to the PCP by the hospital. The PCP prescribed antibiotics to treat the pneumonia, which were administered. The RN indicated that the resident had a post post ER visit follow-up visit with the PCP on June 10, 2010.</p> <p>Record review on September 15, 2010 9:55 a.m. confirmed the discussion with the RN. On September 15, 2010 10:15 a.m., review of the PCP's consultation report dated June 10, 2010, however, revealed "Asthmatic Bronchitis, improved." The PCP also recommended that Resident #2 have a pulmonary consultation.</p> <p>At the time of the survey, however, there was no evidence that the additional studies for more</p>	I 401		

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I 401	Continued From page 9 adequate imaging recommended by the radiologist, or the pulmonary consultation recommended by the PCP had been conducted.	I 401		
I 406	3520.8 PROFESSION SERVICES: GENERAL PROVISIONS  Each professional service provided shall be documented in each resident ' s record.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each professional service provided was documented in each resident's record. (Resident #2)  The findings include:  The facility failed to ensure a consultation report was obtained for Resident #1 after a medical evaluation, due to a change in her health status, as evidenced below:  The review of unusual incident report on September 14, 2010 at 1:17 p.m. revealed on February 2, 2010, staff observed Resident lying on the floor shaking. When called, the resident was unresponsive. ...911 was telephoned and transported the resident to the ER. According to a second incident report, also dated February 2, 2010 (7:00 p.m.), after a CT scan of the brain, and while still in the CT room, the resident had a seizure lasting 3.5 minutes. A CT scan of the resident's abdomen showed left lower lobe pneumonia. The resident was treated for the seizure, then taken back to the ER, where the attending physician determined that the resident should be admitted into the hospital for further observation.	I 406		

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I 406	<p>Continued From page 10</p> <p>Interview with the nurse on September 14, 2010 at 2:15 p.m. revealed the resident was admitted into the hospital for evaluation of her "break-through" seizure activity. According to the nurse, the resident was treated for the aforementioned seizure activity and pneumonia, and remained hospitalized until February 9, 2010.</p> <p>On September 15, 2010 at 2:39 p.m., review of a nursing progress note dated January 28, 2010, revealed the primary care physician was telephoned concerning Resident # 2's "non-productive cough" and vital signs. The PCP ordered "Z Pack", Zythromycin for cough and congestion, which was prescribed on January 29, 2010. A nursing progress note dated February 1, 2010 documented decreased coughing, but lethargy. The progress note further stated that the primary care physician was notified and scheduled the resident an appointment at his office for February 1, 2010 at 3:15 p.m.</p> <p>Interview with the RD and the RN on September 15, 2010 at 2:39 p.m., indicated that the RD took the resident to see the PCP on 2/1/10 as scheduled. The review of available records at the time of the survey, however, revealed there was no PCP progress note of consultation report for Client #2 dated February 1, 2010.</p> <p>Further discussion with the RN on September 15, 2010 at 2:43 p.m. revealed on February 2, 2010, the PCP telephoned the facility, gave laboratory orders, and requested that an appointment be scheduled with the pulmonologist. According to the nurse, forms for the lab work were written at that time, however while attempting to schedule the pulmonology appointment, Resident #2 had the breakthrough seizure-activity, which resulted in her hospitalization.</p>	I 406	<p>1. The Program Coordinator has received additional training on obtaining documentation for professional services. Following medical appointments the consultation form will be faxed to the Director of Health Services and the delegating nurse will be notified. The original consultation record will be filed in the individual's medical record and a progress note will be completed by the RN and/or Program Coordinator as deemed appropriate. The director of Health Services will be notified if there are difficulties obtaining documentation from providers.</p>	<p>10.5.10</p> <p>Ongoing</p>

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I 406	Continued From page 11  There was no evidence that a written report was provided for Resident #2's record, documenting the professional services rendered to her by the PCP on February 1, 2010.  2. The QMRP failed to coordinate services to ensure timely implementation of recommendations to address the needs of Resident #3, as evidenced below:  The review of unusual incident reports on September 15, 2010, at approximately 2:45 p.m., revealed on December 24, 2009, Resident #3 sustained a laceration to the back of her head during a fall, which required sutures. The investigation report, dated December 29, 2009, revealed a recommendation that staff receive updated training by the physical therapist (PT) on fall precautions.  Interview with the QMRP and the registered nurse (RN) on September 15, 2010, revealed that informal training had been provided to the staff prior to this incident. The investigation report further noted that the PT would be contacted to assess the resident after the incident.  Further review of the investigation report dated December 29, 2009 on September 15, 2010 at 5:15 p.m., revealed that a fall risk assessment had been done. The investigation report also stated that some staff had been previously trained. The provided training records, however, revealed no further documentation of training on fall precautions until April 8, 2010. At the time of the survey, there was no evidence staff were provided PT training timely as recommended after the resident's fall.	I 406		

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I 406	Continued From page 12  On September 15, 2010 at 5:17 p.m., the record review revealed that the PT reassessment which was recommended for Resident #3 on December 29, 2009, was not conducted until April 8, 2010. Interview with the QMRP at 5:20 p.m. acknowledged that the PT reassessment was not conducted timely.	I 406			