

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

PRINTED: 06/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2013
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE 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 000	INITIAL COMMENTS A recertification survey was conducted from June 5, 2013 through June 7, 2013. A sample of three clients was selected from a population of five males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and two day programs, interviews with one client's mother, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services implemented each client's mealtime protocol and encourage self-management, for one of three clients in the sample. (Client #2) The finding includes: On June 6, 2013, from 12:09 p.m. - 12:27 p.m., a direct support staff from Client #2's day program (Staff #10) was observed spoon feeding the client his lunch. He was using a specialized spoon with	W 120		

RECEIVED 7/5/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dwanda D. Graham* TITLE: *Program Director* (X6) DATE: *7/5/2013*

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 120	<p>Continued From page 1</p> <p>a built-up handle. The client's milk was observed to have been thickened to a pudding thick consistency. On the previous evening (June 5, 2013), however, at approximately 5:30 p.m., Client #2 had been observed feeding himself independently using a spoon with a built-up handle and his fluids thickened to a nectar consistency. Review of the client's physician's order sheets, at 6:43 p.m. on the previous evening revealed an order for fluids to be thickened to a nectar consistency.</p> <p>On June 7, 2013, beginning at 2:32 p.m., review of Client #2's Individual Support Plan, dated November 30, 2012, and his Mealtime protocol, dated April 13, 2013, and nutrition records revealed that he was able to feed himself but required staff prompts to slow his eating pace. The qualified intellectual disabilities professional (QIDP, Staff #1), who was present at the time, confirmed that Client #2 was able to feed himself. She expressed surprise when informed that a staff person at the day program had been observed spoon feeding him. Continued interview revealed that she had not observed Client #2 receiving lunch at the day program since "at least last November" but had provided a copy of his Mealtime Protocol since it was updated April 13, 2013. Upon review of the Mealtime Protocol, the QIDP noted that it did not reflect the order for thickened fluids to a nectar consistency, as included in the client's physician's dietary orders.</p> <p>There was no evidence that Client #2's day program staff consistently allowed him to feed himself and no evidence that the facility monitored his mealtime services while at day program.</p>	W 120	<p>W120</p> <p>The QIDP will ensure that the relevant day program staff members are re-trained on the meal protocol for Client #2...7-15-13</p> <p>The QIDP will ensure that day program visits and observations are conducted at times that allow for meal observations at least once monthly...7-1-13</p>	

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W 136	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>This STANDARD is not met as evidenced by: Based on interviews with a client's mother and with staff, and record verification, the facility failed to provide opportunities for each client to participate in preferred recreational activities, for one of two clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On June 5, 2013, at 5:40 p.m., an onsite interview with Client #3's mother in the facility revealed that her son's two favorite things to do during leisure time was to go bowling and to play with / manipulate pieces of Lego building blocks. The client's mother stated that she thought he went bowling once a week.</p> <p>On June 6, 2013, at approximately 1:50 p.m., interview with the house manager (Staff #2) revealed that "everyone" went duckpin bowling. Review of Client #3's community outings and recreational activity records for the period January 2013 - June 2013 revealed staff had documented two bowling trips during the 6 months: once in January and once in March. His Activities Calendar, however, reflected bowling on every Wednesday and his Individual Support Plan, dated March 29, 2013, reflected "on Wednesdays, I go... bowling." At 2:24 p.m., follow-up interview with Staff #2 revealed that</p>	W 136	<p>W136</p> <p>The bowling schedule will be changed to Saturdays which will conflict less with bowling tournaments at the chosen location and the QIDP will locate a second location as backup for the primary location...7-1-13 The QIDP will track implementation as documented in the monthly summaries...7-30-13</p>	

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W 136	Continued From page 3 bowling leagues sometimes used the lanes on Wednesdays and the facility had not explored going on other evenings. At the time of the survey, there was no evidence that the facility took Client #3 bowling at the frequency that his mother and interdisciplinary team had recommended.	W 136		
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 observation, interview and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate services and referrals timely (specifically, day program staff did not implement mealtime protocols, residential staff did not ensure preferred community outings as scheduled, and acquire necessary adaptive equipment timely), for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: I. [Cross-refer to W120] The QIDP failed to ensure that day program staff consistently allowed Client #2 to feed himself and provided fluids thickened to a nectar consistency, as follows: On June 6, 2013, from 12:09 p.m. - 12:27 p.m., a direct support staff from Client #2's day program	W 159	W159 The knee braces and shoes have been ordered and will be received by...7-15-13 The weighted vest has been received and is being used...6-9-13 The multi-sensory ball will be delivered by the OT by...6-30-13 The management team will track all adaptive equipment considerations for everyone supported during weekly management team meetings (Mondays); it is the responsibility of the QIDP to track and report on all adaptive equipment needs including repair considerations...7-1-13 The QIDP will meet this obligation via on site audits conducted each month...7-1-13	

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W 159 Continued From page 4
(Staff #10) was observed spoon feeding the client his lunch. He was using a specialized spoon with a built-up handle. The client's milk was observed to have been thickened to a pudding thick consistency. On the previous evening (June 5, 2013), however, at approximately 5:30 p.m., Client #2 had been observed feeding himself independently using a spoon with a built-up handle and his fluids thickened to a nectar consistency. Review of the client's physician's order sheets, at 6:43 p.m. on the previous evening revealed an order for fluids to be thickened to a nectar consistency.

On June 7, 2013, beginning at 2:32 p.m., review of Client #2's Individual Support Plan, dated November 30, 2012, and his Mealtime protocol, dated April 13, 2013, and nutrition records revealed that he was able to feed himself but required staff prompts to slow his eating pace. The qualified intellectual disabilities professional (QIDP, Staff #1), who was present at the time, confirmed that Client #2 was able to feed himself. She expressed surprise when informed that a staff person at the day program had been observed spoon feeding him. Continued interview revealed that she had not observed Client #2 receiving lunch at the day program since "at least last November" but had provided a copy of his Mealtime Protocol since it was updated April 13, 2013. Upon review of the Mealtime Protocol, the QIDP noted that it did not reflect the order for thickened fluids to a nectar consistency, as included in the client's physician's dietary orders.

II. Cross-refer to W136]
The QIDP failed to ensure that Client #3 participated in his preferred recreational activity in

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W 159	<p>Continued From page 5</p> <p>the community (i.e. bowling), at the frequency (weekly) that was outlined in his plan, as follows:</p> <p>On June 5, 2013, at 5:40 p.m., interview with Client #3's mother in the facility revealed that her son's two favorite leisure activities were manipulating Legos and bowling. She further stated he went bowling once a week.</p> <p>On June 6, 2013, beginning at approximately 2:00 p.m., review of Client #3's community outings and recreational activity records for the six-month period January 2013 - June 2013 revealed staff had documented two bowling trips. His Activities Calendar and his Individual Support Plan, dated March 29, 2013, reflected bowling every Wednesday. At 2:24 p.m., interview with the house manager (Staff #2) revealed that bowling leagues sometimes used the lanes on Wednesdays and the facility had not explored going on other evenings.</p> <p>III. [Cross-refer to W436] The QIDP failed to secure needed adaptive equipment timely for Client #1, as follows:</p> <p>A. On June 5, 2013, at 3:59 p.m., Client #1 was observed entering the facility with two direct support staff (Staff #7 and #8). The staff were walking to either side of the client, holding him by a gait belt. He was wearing a protective helmet with face guard and black sneakers. These items were observed being worn and/or used through the next 2 1/2 hours.</p> <p>On June 5, 2013, beginning at 6:33 p.m., review of Client #1's physician's order sheets (POS) dated June 1, 2013 revealed orders for a gait</p>	W 159			

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W 159	<p>Continued From page 6</p> <p>belt, leg brace, plate guard and protective helmet. No leg braces, however, had been observed on the client.</p> <p>On June 6, 2013, a direct support staff (Staff #9) was interviewed in Client #1's bedroom, beginning at 7:06 a.m. When asked about leg braces, he stated he had not seen leg braces used since he began working with Client #1 in January 2013.</p> <p>On June 7, 2013, beginning at 9:45 a.m., review of Client #1's health and habilitation records revealed the following:</p> <ul style="list-style-type: none"> - Physician's orders dated January 18, 2013 (his admitting orders), included the gait belt, leg brace, plate guard and protective helmet; - February 6, 2013: physical therapist recommended "follow-up with braces and shoes from <hospital>. The braces should accommodate his ankle plantar flexion contractures;" - March 21, 2013: primary care physician (PCP) wrote two prescriptions: one for "bilateral AFO's (ankle-foot orthotics) 1 pair shoes and inserts," the other was for "bilateral knee braces 1 pair;" - April 17, 2013: Client #1 was uncooperative in the orthopedic clinic and could not be assessed. The clinic wrote "Patient needs to be sedated. Call us when he is able to be sedated;" - April 19, 2013: PCP wrote a prescription for Ativan 2 milligrams, prior to appointment; - June 6, 2013: Client #1's medical guardian signed a consent form for sedation prior to an appointment scheduled June 25, 2013, "evaluation for Bilateral AFO's with orthopedic shoes with inserts." 	W 159		

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W 159	<p>Continued From page 7</p> <p>On June 7, 2013, at approximately 12:25 p.m., the QIDP explained that the facility had to obtain new orders from Client #1's current PCP. She acknowledged that 8 weeks passed between the client's admission (January 18, 2013) and the date (March 21, 2013) the PCP prescribed AFO's, orthopedic shoes and knee braces. She further acknowledged that Client #1 remained without the prescribed leg braces and orthopedic shoes 5 months after he was admitted to the facility.</p> <p>B. On June 7, 2013, beginning at approximately 12:30 p.m., review of Client #1's Occupational Therapy Evaluation, dated February 11, 2013 revealed the consulting occupational therapist (OT) had recommended the facility obtain a weighted vest and multi-sensory ball. When asked about the vest and ball, at approximately 12:35 p.m., the QIDP stated that the interdisciplinary team (IDT) had agreed with the recommendation when it convened for the client's 30-day review meeting on February 17, 2013. At 12:40 p.m., the QIDP was observed speaking with the OT by telephone, during which the OT reportedly agreed to obtain the weighted vest and the multi-sensory ball. She acknowledged that almost 4 months had passed since the equipment had been recommended by the IDT.</p>	W 159		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that (1) each</p>	W 331		

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W 331	<p>Continued From page 8</p> <p>client who was prescribed a restriction on fluid intake received nursing oversight to ensure compliance with the physician's orders; (2) all staff received effective training on thickening fluids to the prescribed consistency; and (3) all nurses poured liquid medications in a manner that ensured accuracy, for three of five clients residing in the facility. (Clients #2, #3 and #4)</p> <p>The findings include:</p> <p>I. The facility's nursing services failed to ensure compliance with Client #3' prescribed fluid restriction by the team of medication nurses, as follows:</p> <p>On June 5, 2013, at 5:13 p.m., Client #3 was observed drinking 8 ounce (oz) of water with his evening medication regimen. Beginning at 6:56 p.m., review of the client's current physician's order sheets (POS), dated June 1, 2013, revealed the client was to receive 1000 cubic centimeters (cc's) daily, with an additional 30 cc's of water with each medication administration. This reflected an increase in his daily fluid intake "to lower" his blood urea nitrogen (BUN) levels.</p> <p>On June 6, 2013, at approximately 4:10 p.m., interview with the administrative nurse (Staff #6) confirmed that Client #3 was to only receive 30 cc's with his medications. At 4:18 p.m., the evening medication nurse (Staff #5) arrived and asked for feedback regarding observations made the previous evening. When discussing Client #3's water, Staff #5 confirmed the client had been given 8 oz. (240 cc's) with his medications. She indicated that she routinely gave him the 8 oz., explaining that 30 cc's might not be enough</p>	W 331	<p>W331</p> <p>The RN will retrain the medication nurse to ensure she follows the medication administration protocol and the mandates outlined on the physician's orders. She will also be trained to report any issues she has or suggestions to the RN and PCP for follow up rather than make changes on her own that are inconsistent with standing orders and protocols...7-1-13</p> <p>The RN will also retrain the staff on adhering to the 1000cc mandate for meals and snacks. The RN will ensure that staff is properly trained to measure the amounts of water properly...7-7-13</p> <p>Fluid intake chart data will be recorded in Therap and the RN will be instructed to review the data in Therap and during home visits no less than weekly...7-1-13</p> <p>The RN will document the reviews (signature and dates)...beginning 7-1-13</p> <p>The LPN will be retrained by the RN on how to properly measure liquid medications and will observe the LPN completing this task at least once weekly for at minimum one month beginning...7-1-13</p> <p>Should the RN observe improper measuring, she will provide on-the-spot training and will continue to observe weekly at minimum until the LPN performs the task with 100% efficiency for four consecutive weeks at which point the observation intervals will be reduced...7-1-13</p> <p>The QIDP and home manager will also observe the LPN at least once weekly (separately) and will report to the RN their observations in Therap...7-1-13</p>	

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W 331	<p>Continued From page 9</p> <p>volume to ensure he swallowed all of his medications. When asked, she acknowledged that she had not brought her concerns about this issue to the attention of her supervisors or the primary care physician (PCP).</p> <p>It should be noted that on June 7, 2013, at approximately 2:05 p.m., Staff #6 presented a new telephone order from the PCP, dated June 7, 2013 that reflected "May give an additional 30 cc's, up to 60 cc's with each med pass to assist with swallowing medications safely."</p> <p>It should be further noted that on June 7, 2013, at approximately 1:55 p.m., the facility's special projects officer (Staff #3) stated that she could find no documented evidence that their medication nurses had received training on Client #3's fluid restriction orders, to include the 30 cc's given with medications.</p> <p>II. The facility's nursing services failed to ensure that the direct support staff received effective training on Client #3's fluid restriction, as follows:</p> <p>On June 7, 2013, at approximately 1:15 p.m., review of monthly charts on which staff documented the amount of fluids Client #3 received at his meals and snacks revealed that on May 3, 2013, staff documented that he received 1448 cc's fluids that day. On both June 5 and on June 6, 2013, staff documented that he received 1100 cc's fluids. The client's POS, however, limited his daily fluid intake to 1000 cc's at meals and snacks. On June 7, 2013, at approximately 1:50 p.m., Staff #3 presented a signature sheet, dated April 23, 2013, that documented that the qualified intellectual</p>	W 331		

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W 331	<p>Continued From page 10</p> <p>disabilities professional (QIDP, Staff #1) had trained 17 staff on the client's mealtime protocol, including his fluid restriction orders. Documentation maintained by staff on May 3, 2013, June 5, 2013 and June 6, 2013 indicated that the training had not been effective.</p> <p>III. Review of Client #3's nursing records and fluid intake sheets revealed no evidence the consulting registered nurse (RN, Staff #4) had reviewed his fluid intake data. On June 7, 2013, at 12:55 p.m., review of the contract between the facility and Staff #4, signed September 3, 2012, revealed she was to "supervise the licensed practical nurses and medication pass" and "maintain a deficiency-free nursing program." At 4:45 p.m., the QIDP attempted to reach Staff #4 by telephone; however, there was no opportunity presented to interview her before the survey ended at 5:15 p.m.</p> <p>IV. The facility's nursing services failed to ensure that all nurses poured liquid medications in a manner that ensured accuracy, as follows:</p> <p>[Cross-refer to W369] On June 5, 2012, at 4:45 p.m., the evening medication nurse (Staff #5) was observed pouring Constulose stool softener into a medication cup. After she poured what she stated was 30 milliliters (ml) of Constulose, she placed the cup on a tray and began preparing the next medication. Staff #5 was then asked to place the Constulose where this surveyor could verify the amount. She retrieved the cup and placed it atop a file cabinet. She then observed the medication did not reach the 30 ml line (approx. 27 ml). Staff #5 reopened the Constulose bottle and poured</p>	W 331		

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W 331	Continued From page 11 another 3 ml (approximately) to equal 30 ml. On June 7, 2013, at 12:55 p.m., review of the contract between the facility and their consulting registered nurse (Staff #4), signed September 3, 2012, revealed she was to "supervise the licensed practical nurses and medication pass" and "maintain a deficiency-free nursing program." At 4:45 p.m., the QIDP attempted to reach Staff #4 by telephone; however, there was no opportunity presented to interview her before the survey ended at 5:15 p.m. At the time of the survey, there was no evidence that the supervisory RN had observed the evening medication nurse administer medications in the facility, to ensure compliance with physician's orders.	W 331		
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 ensure that each client's medications were administered without error, for one of five clients residing in the facility. (Client #4) The finding includes: On June 5, 2012, at 4:45 p.m., the evening medication nurse (Staff #5) was observed pouring Constulose stool softener into a small plastic medication cup. After she poured what she	W 369		

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W 369	Continued From page 12 stated was 30 milliliters (ml) of Constulose, she placed the cup on a tray and began preparing the next medication. When Staff #5 was asked to place the medication cup on a level surface for inspection, she placed it atop a file cabinet. Observation of the medication cup revealed approximately 27 ml of Constulose. Immediately, she reopened the Constulose bottle and poured another 3 ml (approximately) which brought the meniscus up to 30 ml. On June 6, 2013, at 8:22 a.m., review of Client #4's physician's order sheets and medication administration records for June 2013 confirmed that he was prescribed Constulose 30 ml daily for constipation.	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement a system to ensure that each client received timely recommended adaptive equipment such as leg braces, orthopedic shoes, weighted vests and multi-sensory balls, for one of three clients in the sample. (Client #1) The findings include:	W 436	436 The knee braces and shoes have been ordered and will be received by...7-15-13 The weighted vest has been received and is being used...6-9-13 The multi-sensory ball will be delivered by the OT by...6-30-13 The management team will track all adaptive equipment considerations for everyone supported during weekly management team meetings (Mondays); it is the responsibility of the QIDP to track and report on all adaptive equipment needs including repair considerations...7-1-13 The QIDP will meet this obligation via on site audits conducted each month...7-1-13	

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W 436	<p>Continued From page 13</p> <p>I. The facility failed to secure leg braces and orthopedic shoes timely for Client #1, as follows:</p> <p>During the entrance conference on June 5, 2013, at approximately 1:45 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) indicated that Client #1 had been admitted in January 2013. She stated he was assigned two staff at all times, 24 hours per day, 7 days per week, to ensure his safety while ambulating and to address his maladaptive behaviors, which included banging his head on walls and kicking others.</p> <p>On June 5, 2013, at 3:59 p.m., Client #1 was observed entering the facility's front door. Two direct support staff (Staff #7 and #8) were walking to either side of the client, holding him by a gait belt. He was wearing a protective helmet with face guard and black sneakers. These items were observed being worn and/or used through the next 2 1/2 hours.</p> <p>On June 5, 2013, beginning at 6:33 p.m., review of Client #1's physician's order sheets (POS) dated June 1, 2013 revealed orders for a gait belt, leg brace, plate guard and protective helmet. No leg braces, however, had been observed on the client.</p> <p>On June 6, 2013, a direct support staff (Staff #9) was interviewed in Client #1's bedroom, beginning at 7:06 a.m. At the time, Client #1 was seated in a recliner, wearing his protective helmet, gait belt and black sneakers. The staff said he worked from 12:00 a.m. - 8:00 a.m. and routinely got the client dressed and ready for the day. When asked about leg braces, he stated he</p>	W 436		

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W 436 Continued From page 14
had not seen leg braces used since he began working with Client #1 in January 2013.

On June 7, 2013, beginning at 9:45 a.m., review of Client #1's health and habilitation records revealed the following:

- On December 19, 2012 (immediately prior to admission), he was measured for braces and orthopedic shoes at a specialty clinic;
- Physician's orders dated January 18, 2013 (his admitting orders), included the gait belt, leg brace, plate guard and protective helmet;
- On February 6, 2013, the physical therapist evaluated Client #1, and recommended "follow-up with braces and shoes from <hospital>. The braces should accommodate his ankle plantarflexion contractures;"
- On March 21, 2013, the primary care physician (PCP, Staff #12) wrote two prescriptions: one was for "bilateral AFO's (ankle-foot orthotics) 1 pair shoes and inserts" and the other was for "bilateral knee braces 1 pair;"
- A consultation form dated April 17, 2013, documented that Client #1 was uncooperative in a specialty orthopedic clinic and could not be assessed. The clinic wrote "Patient needs to be sedated. Call us when he is able to be sedated;"
- On April 19, 2013, the PCP wrote a prescription for Ativan 2 milligrams, prior to appointment;
- On June 6, 2013, the client's medical guardian signed a consent form for sedation prior to an appointment scheduled June 25, 2013, "evaluation for Bilateral AFO's with orthopedic shoes with inserts."

On June 7, 2013, at approximately 12:25 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) explained that the specialty

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W 436	<p>Continued From page 15</p> <p>orthopedic clinic would not honor the former PCP's prescription; therefore, the facility had to obtain new orders from Client #1's current PCP. She acknowledged that 8 weeks passed between the client's admission (January 18, 2013) and the date (March 21, 2013) the PCP prescribed AFO's, orthopedic shoes and knee braces. She further acknowledged that Client #1 remained without the prescribed leg braces and orthopedic shoes 5 months after he was admitted to the facility.</p> <p>II. On June 7, 2013, beginning at approximately 12:30 p.m., review of Client #1's Occupational Therapy Evaluation, dated February 11, 2013 revealed the consulting occupational therapist (OT, Staff #11) had recommended the facility obtain a weighted vest and multi-sensory ball. When asked about the vest and ball, at approximately 12:35 p.m., the QIDP stated that the interdisciplinary team (IDT) had agreed with the recommendation when it convened for the client's 30-day review meeting on February 15, 2013. The QIDP further stated that she had asked the OT for assistance in acquiring the proper type of vest. At 12:40 p.m., the QIDP was observed speaking with the OT by telephone. After their conversation, she stated the OT had agreed to obtain the weighted vest and the multi-sensory ball "as soon as possible." She acknowledged that almost 4 months had passed since the equipment had been recommended by the IDT.</p> <p>There was no evidence the facility furnished needed adaptive equipment timely.</p>	W 436	<p>436</p> <p>The knee braces and shoes have been ordered and will be received by...7-15-13 The weighted vest has been received and is being used...6-9-13 The multi-sensory ball will be delivered by the OT by...6-30-13 The management team will track all adaptive equipment considerations for everyone supported during weekly management team meetings (Mondays); it is the responsibility of the QIDP to track and report on all adaptive equipment needs including repair considerations...7-1-13 The QIDP will meet this obligation via on site audits conducted each month...7-1-13</p>	
W 441	483.470(i)(1) EVACUATION DRILLS	W 441		

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W 441	<p>Continued From page 16</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that fire drills were scheduled for all times of the day and night, for five of five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>On June 6, 2013, beginning at 4:33 p.m., review of the fire drill records in the facility for the period May 2012 - May 2013 revealed no evidence that drills had been held by the overnight shift (12:00 a.m. - 8:00 a.m.) while clients were asleep in their beds. Staff on that shift had documented drills conducted between 6:00 a.m. - 7:40 a.m., noting that the clients were awake at the time of each drill.</p> <p>On June 7, 2013, at approximately 12:14 p.m., the house manager (Staff #2) indicated that he had reviewed the fire drill reports and confirmed the aforementioned findings. He presented the schedules for 2012 and 2013, explaining that the facility had not scheduled drills specifically for late-night hours, while clients were asleep. He further stated that management would address the issue.</p>	W 441	<p>W441</p> <p>The QIDP will revise the remainder of the Annual Fire Drill Schedule (July – December of 2013) to ensure that drills are implemented during sleeping hours...7-1-13. The QIDP will also ensure that a drill is implemented by 7-5-13 during sleeping hours to cover the last quarter omission (April – June)...7-5-13</p>		

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1 000	INITIAL COMMENTS A licensure survey was conducted from June 5, 2013 through June 7, 2013. A sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident's mother, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000	
1 090	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 and interview, the group home for individuals with intellectual disabilities (GHIID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, with the exception of the following two concerns, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: I. Observations during the inspection of the	1 090	3504.1 The carpet was repaired and the trip hazard abated...6-10-13 The common bathroom was re-caulked on...6-10-13 The home manager will conduct weekly environmental audits and provide findings to the administrator for review and follow up...7-1-13

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

Linda Seahorn

TITLE

Program Director

(X6) DATE

7/5/2013

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I 090	Continued From page 1 environment on June 7, 2013, at 10:10 a.m. revealed damage to the carpet (approximately 6-inch tear) on the 3rd step of the front steps. The tear presented a potential trip hazard. II. At approximately 11:00 a.m., observations in the common bathroom located in the bedroom hallway revealed the caulking around the top edge of the bathtub was cracked and/or missing. Staff #1 stated that she would make maintenance aware of the aforementioned concerns.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT 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 observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated services and referrals timely (specifically, day program staff did not implement mealtime protocols, residential staff did not ensure preferred community outings as scheduled, and acquire necessary adaptive equipment timely), for three of three residents in the sample. (Residents #1, #2 and #3) The findings include: I. The QIDP failed to ensure that day program staff consistently allowed Resident #2 to feed himself and provided fluids thickened to a nectar consistency, as follows:	I 180	The QIDP will ensure that the relevant day program staff members are re-trained on the meal protocol for Client #2...7-15-13 The QIDP will ensure that day program visits and observations are conducted at times that allow for meal observations at least once monthly...7-1-13	

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I 180	Continued From page 2 On June 6, 2013, from 12:09 p.m. - 12:27 p.m., a direct support staff from Resident #2's day program (Staff #10) was observed spoon feeding the resident his lunch. He was using a specialized spoon with a built-up handle. The resident's milk was observed to have been thickened to a pudding thick consistency. On the previous evening (June 5, 2013), however, at approximately 5:30 p.m., Resident #2 had been observed feeding himself independently using a spoon with a built-up handle and his fluids thickened to a nectar consistency. Review of the resident's physician's order sheets, at 6:43 p.m. on the previous evening revealed an order for fluids to be thickened to a nectar consistency. On June 7, 2013, beginning at 2:32 p.m., review of Resident #2's Individual Support Plan, dated November 30, 2012, and his Mealtime protocol, dated April 13, 2013, and nutrition records revealed that he was able to feed himself but required staff prompts to slow his eating pace. The qualified intellectual disabilities professional (QIDP, Staff #1), who was present at the time, confirmed that Resident #2 was able to feed himself. She expressed surprise when informed that a staff person at the day program had been observed spoon feeding him. Continued interview revealed that she had not observed Resident #2 receiving lunch at the day program since "at least last November" but had provided a copy of his Mealtime Protocol since it was updated April 13, 2013. Upon review of the Mealtime Protocol, the QIDP noted that it did not reflect the order for thickened fluids to a nectar consistency, as included in the resident's physician's dietary orders. II. [Cross-refer to I500.II] The QIDP failed to secure needed adaptive equipment timely for	I 180			

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I 180	Continued From page 3 Resident #1, as follows: A. On June 5, 2013, at 3:59 p.m., Resident #1 was observed entering the facility with two direct support staff (Staff #7 and #8). The staff were walking to either side of the resident, holding him by a gait belt. He was wearing a protective helmet with face guard and black sneakers. These items were observed being worn and/or used through the next 2 1/2 hours. On June 5, 2013, beginning at 6:33 p.m., review of Resident #1's physician's order sheets (POS) dated June 1, 2013 revealed orders for a gait belt, leg brace, plate guard and protective helmet. No leg braces, however, had been observed on the resident. On June 6, 2013, a direct support staff (Staff #9) was interviewed in Resident #1's bedroom, beginning at 7:06 a.m. When asked about leg braces, he stated he had not seen leg braces used since he began working with Resident #1 in January 2013. On June 7, 2013, beginning at 9:45 a.m., review of Resident #1's health and habilitation records revealed the following: - Physician's orders dated January 18, 2013 (his admitting orders), included the gait belt, leg brace, plate guard and protective helmet; - February 6, 2013: physical therapist recommended "follow-up with braces and shoes from <hospital>. The braces should accommodate his ankle plantar flexion contractures;" - March 21, 2013: primary care physician (PCP) wrote two prescriptions: one for "bilateral AFO's (ankle-foot orthotics) 1 pair shoes and inserts," the other was for "bilateral knee braces 1 pair;"	I 180		

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I 180	<p>Continued From page 4</p> <ul style="list-style-type: none"> - April 17, 2013: Resident #1 was uncooperative in the orthopedic clinic and could not be assessed. The clinic wrote "Patient needs to be sedated. Call us when he is able to be sedated;" - April 19, 2013: PCP wrote a prescription for Ativan 2 milligrams, prior to appointment; - June 6, 2013: Resident #1's medical guardian signed a consent form for sedation prior to an appointment scheduled June 25, 2013, "evaluation for Bilateral AFO's with orthopedic shoes with inserts." <p>On June 7, 2013, at approximately 12:25 p.m., the QIDP explained that the facility had to obtain new orders from Resident #1's current PCP. She acknowledged that 8 weeks passed between the resident's admission (January 18, 2013) and the date (March 21, 2013) the PCP prescribed AFO's, orthopedic shoes and knee braces. She further acknowledged that Resident #1 remained without the prescribed leg braces and orthopedic shoes 5 months after he was admitted to the facility.</p> <p>B. On June 7, 2013, beginning at approximately 12:30 p.m., review of Resident #1's Occupational Therapy Evaluation, dated February 11, 2013 revealed the consulting occupational therapist (OT) had recommended the facility obtain a weighted vest and multi-sensory ball. When asked about the vest and ball, at approximately 12:35 p.m., the QIDP stated that the interdisciplinary team (IDT) had agreed with the recommendation when it convened for the resident's 30-day review meeting on February 17, 2013. At 12:40 p.m., the QIDP was observed speaking with the OT by telephone, during which the OT reportedly agreed to obtain the weighted vest and the multi-sensory ball. She acknowledged that almost 4 months had passed</p>	I 180		

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I 180	<p>Continued From page 5</p> <p>since the equipment had been recommended by the IDT.</p> <p>III. [Cross-refer to I500.III] The QIDP failed to ensure that Resident #3 participated in his preferred recreational activity in the community (i.e. bowling), at the frequency (weekly) that was outlined in his plan, as follows:</p> <p>On June 5, 2013, at 5:40 p.m., interview with Resident #3's mother in the facility revealed that her son's two favorite leisure activities were manipulating Legos and bowling. She further stated he went bowling once a week</p> <p>On June 6, 2013, beginning at approximately 2:00 p.m., review of Resident #3's community outings and recreational activity records for the six-month period January 2013 - June 2013 revealed staff had documented two bowling trips. His Activities Calendar and his Individual Support Plan, dated March 29, 2013, reflected bowling every Wednesday. At 2:24 p.m., interview with the house manager (Staff #2) revealed that bowling leagues sometimes used the lanes on Wednesdays and the facility had not explored going on other evenings.</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> <p>This Statute is not met as evidenced by: Based on observation, interview and record</p>	I 401		

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I 401	<p>Continued From page 6</p> <p>review, the group home for individuals with intellectual disabilities (GHIID) failed to failed to ensure that (1) each resident who was prescribed a restriction on fluid intake received nursing oversight to ensure compliance with the physician's orders; (2) all staff received effective training on thickening fluids to the prescribed consistency; and (3) all nurses poured liquid medications in a manner that ensured accuracy, for three of five residents residing in the facility. (Residents #2, #3 and #4)</p> <p>The findings include:</p> <p>I. The facility's nursing services failed to ensure compliance with Resident #3' prescribed fluid restriction by the team of medication nurses, as follows:</p> <p>On June 5, 2013, at 5:13 p.m., Resident #3 was observed drinking 8 ounce (oz) of water with his evening medication regimen. Beginning at 6:56 p.m., review of the resident's current physician's order sheets (POS), dated June 1, 2013, revealed the resident was to receive 1000 cubic centimeters (cc's) daily, with an additional 30 cc's of water with each medication administration. This reflected an increase in his daily fluid intake "to lower" his blood urea nitrogen (BUN) levels.</p> <p>On June 6, 2013, at approximately 4:10 p.m., interview with the administrative nurse (Staff #6) confirmed that Resident #3 was to only receive 30 cc's with his medications. At 4:18 p.m., the evening medication nurse (Staff #5) arrived and asked for feedback regarding observations made the previous evening. When discussing Resident #3's water, Staff #5 confirmed the resident had been given 8 oz. (240 cc's) with his medications. She indicated that she routinely gave him the 8</p>	I 401	<p>The RN will retrain the medication nurse to ensure she follows the medication administration protocol and the mandates outlined on the physician's orders. She will also be trained to report any issues she has or suggestions to the RN and PCP for follow up rather than make changes on her own that are inconsistent with standing orders and protocols...7-1-13</p> <p>The RN will also retrain the staff on adhering to the 1000cc mandate for meals and snacks. The RN will ensure that staff is properly trained to measure the amounts of water properly...7-7-13</p> <p>Fluid intake chart data will be recorded in Therap and the RN will be instructed to review the data in Therap and during home visits no less than weekly...7-1-13</p> <p>The RN will document the reviews (signature and dates)...beginning 7-1-13</p> <p>The LPN will be retrained by the RN on how to properly measure liquid medications and will observe the LPN completing this task at least once weekly for at minimum one month beginning...7-1-13</p> <p>Should the RN observe improper measuring, she will provide on-the-spot training and will continue to observe weekly at minimum until the LPN performs the task with 100% efficiency for four consecutive weeks at which point the observation intervals will be reduced...7-1-13</p> <p>The QIDP and home manager will also observe the LPN at least once weekly (separately) and will report to the RN their observations in Therap...7-1-13</p>	
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I 401	<p>Continued From page 7</p> <p>oz., explaining that 30 cc's might not be enough volume to ensure he swallowed all of his medications. When asked, she acknowledged that she had not brought her concerns about this issue to the attention of her supervisors or the primary care physician (PCP).</p> <p>It should be noted that on June 7, 2013, at approximately 2:05 p.m., Staff #6 presented a new telephone order from the PCP, dated June 7, 2013 that reflected "May give an additional 30 cc's, up to 60 cc's with each med pass to assist with swallowing medications safely."</p> <p>It should be further noted that on June 7, 2013, at approximately 1:55 p.m., the facility's special projects officer (Staff #3) stated that she could find no documented evidence that their medication nurses had received training on Resident #3's fluid restriction orders, to include the 30 cc's given with medications.</p> <p>II. The facility's nursing services failed to ensure that the direct support staff received effective training on Resident #3's fluid restriction, as follows:</p> <p>On June 7, 2013, at approximately 1:15 p.m., review of monthly charts on which staff documented the amount of fluids Resident #3 received at his meals and snacks revealed that on May 3, 2013, staff documented that he received 1448 cc's fluids that day. On both June 5 and on June 6, 2013, staff documented that he received 1100 cc's fluids. The resident's POS, however, limited his daily fluid intake to 1000 cc's at meals and snacks. On June 7, 2013, at approximately 1:50 p.m., Staff #3 presented a signature sheet, dated April 23, 2013, that documented that th qualified intellectual</p>	I 401	

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I 401	<p>Continued From page 8</p> <p>disabilities professional (QIDP, Staff #1) had trained 17 staff on the resident's mealtime protocol, including his fluid restriction orders. Documentation maintained by staff on May 3, 2013, June 5, 2013 and June 6, 2013 indicated that the training had not been effective.</p> <p>III. Review of Resident #3's nursing records and fluid intake sheets revealed no evidence the consulting registered nurse (RN, Staff #4) had reviewed his fluid intake data. On June 7, 2013, at 12:55 p.m., review of the contract between the facility and Staff #4, signed September 3, 2012, revealed she was to "supervise the licensed practical nurses and medication pass" and "maintain a deficiency-free nursing program." At 4:45 p.m., the QIDP attempted to reach Staff #4 by telephone; however, there was no opportunity presented to interview her before the survey ended at 5:15 p.m.</p> <p>IV. The facility's nursing services failed to ensure that all nurses poured liquid medications in a manner that ensured accuracy, as follows:</p> <p>On June 5, 2012, at 4:45 p.m., the evening medication nurse (Staff #5) was observed pouring Constulose stool softener into a medication cup. After she poured what she stated was 30 milliliters (ml) of Constulose, she placed the cup on a tray and began preparing the next medication. When Staff #5 was asked to place the medication cup on a level surface for inspection, she placed it atop a file cabinet. Observation of the medication cup revealed approximately 27 ml of Constulose. Immediately, she reopened the Constulose bottle and poured another 3 ml (approximately) which brought the meniscus up to 30 ml.</p>	I 401		

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I 401	Continued From page 9 On June 7, 2013, at 12:55 p.m., review of the contract between the facility and their consulting registered nurse (Staff #4), signed September 3, 2012, revealed she was to "supervise the licensed practical nurses and medication pass" and "maintain a deficiency-free nursing program." At 4:45 p.m., the QIDP attempted to reach Staff #4 by telephone; however, there was no opportunity presented to interview her before the survey ended at 5:15 p.m. At the time of the survey, there was no evidence that the supervisory RN had observed the evening medication nurse administer medications in the facility, to ensure compliance with physician's orders.	I 401	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of three residents of the facility. (Residents #1 and #3) The findings include:	I 500	

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I 500	<p>Continued From page 10</p> <p>I. [483.470(g)(2)] The GHIID failed to ensure timely acquisition of prescribed adaptive equipment, as follows:</p> <p>A. The GHIID failed to secure leg braces and orthopedic shoes timely for Resident #1, as follows:</p> <p>During the entrance conference on June 5, 2013, at approximately 1:45 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) indicated that Resident #1 had been admitted in January 2013. She stated he was assigned two staff at all times, 24 hours per day, 7 days per week, to ensure his safety while ambulating and to address his maladaptive behaviors, which included banging his head on walls and kicking others.</p> <p>On June 5, 2013, at 3:59 p.m., Resident #1 was observed entering the facility's front door. Two direct support staff (Staff #7 and #8) were walking to either side of the resident, holding him by a gait belt. He was wearing a protective helmet with face guard and black sneakers. These items were observed being worn and/or used through the next 2 1/2 hours.</p> <p>On June 5, 2013, beginning at 6:33 p.m., review of Resident #1's physician's order sheets (POS) dated June 1, 2013 revealed orders for a gait belt, leg brace, plate guard and protective helmet. No leg braces, however, had been observed on the resident.</p> <p>On June 6, 2013, a direct support staff (Staff #9) was interviewed in Resident #1's bedroom, beginning at 7:06 a.m. At the time, Resident #1 was seated in a recliner, wearing his protective</p>	I 500	<p>The knee braces and shoes have been ordered and will be received by...7-15-13 The weighted vest has been received and is being used...6-9-13 The multi-sensory ball will be delivered by the OT by...6-30-13 The management team will track all adaptive equipment considerations for everyone supported during weekly management team meetings (Mondays); it is the responsibility of the QIDP to track and report on all adaptive equipment needs including repair considerations...7-1-13 The QIDP will meet this obligation via on site audits conducted each month...7-1-13</p>	
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I 500	<p>Continued From page 11</p> <p>helmet, gait belt and black sneakers. The staff said he worked from 12:00 a.m. - 8:00 a.m. and routinely got the resident dressed and ready for the day. When asked about leg braces, he stated he had not seen leg braces used since he began working with Resident #1 in January 2013.</p> <p>On June 7, 2013, beginning at 9:45 a.m., review of Resident #1's health and habilitation records revealed the following:</p> <ul style="list-style-type: none"> - On December 19, 2012 (immediately prior to admission), he was measured for braces and orthopedic shoes at a specialty clinic; - Physician's orders dated January 18, 2013 (his admitting orders), included the gait belt, leg brace, plate guard and protective helmet; - On February 6, 2013, the physical therapist evaluated Resident #1, and recommended "follow-up with braces and shoes from <hospital>. The braces should accommodate his ankle plantarflexion contractures;" - On March 21, 2013, the primary care physician (PCP, Staff #12) wrote two prescriptions: one was for "bilateral AFO's (ankle-foot orthotics) 1 pair shoes and inserts" and the other was for "bilateral knee braces 1 pair;" - A consultation form dated April 17, 2013, documented that Resident #1 was uncooperative in a specialty orthopedic clinic and could not be assessed. The clinic wrote "Patient needs to be sedated. Call us when he is able to be sedated;" - On April 19, 2013, the PCP wrote a prescription for Ativan 2 milligrams, prior to appointment; - On June 6, 2013, the resident's medical guardian signed a consent form for sedation prior to an appointment scheduled June 25, 2013, "evaluation for Bilateral AFO's with orthopedic shoes with inserts." <p>On June 7, 2013, at approximately 12:25 p.m.,</p>	I 500	

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I 500	<p>Continued From page 12</p> <p>the qualified intellectual disabilities professional (QIDP, Staff #1) explained that the specialty orthopedic clinic would not honor the former PCP's prescription; therefore, the facility had to obtain new orders from Resident #1's current PCP. She acknowledged that 8 weeks passed between the resident's admission (January 18, 2013) and the date (March 21, 2013) the PCP prescribed AFO's, orthopedic shoes and knee braces. She further acknowledged that Resident #1 remained without the prescribed leg braces and orthopedic shoes 5 months after he was admitted to the facility.</p> <p>B. On June 7, 2013, beginning at approximately 12:30 p.m., review of Resident #1's Occupational Therapy Evaluation, dated February 11, 2013 revealed the consulting occupational therapist (OT, Staff #11) had recommended the facility obtain a weighted vest and multi-sensory ball. When asked about the vest and ball, at approximately 12:35 p.m., the QIDP stated that the interdisciplinary team (IDT) had agreed with the recommendation when it convened for the resident's 30-day review meeting on February 15, 2013. The QIDP further stated that she had asked the OT for assistance in acquiring the proper type of vest. At 12:40 p.m., the QIDP was observed speaking with the OT by telephone. After their conversation, she stated the OT had agreed to obtain the weighted vest and the multi-sensory ball "as soon as possible." She acknowledged that almost 4 months had passed since the equipment had been recommended by the IDT.</p> <p>II. [483.460(c)] The GHIID failed to ensure Resident #3's right to receive health care services, to include monitoring and oversight by licensed professionals, to ensure compliance with</p>	I 500		

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I 500	<p>Continued From page 13</p> <p>his physician-ordered fluid restriction, as follows:</p> <p>A. [Cross-reference to I401] On June 5, 2013, at 5:13 p.m., Resident #3 was observed drinking 8 ounce (oz) of water with his evening medication regimen. Beginning at 6:56 p.m., review of the resident's current physician's order sheets (POS), dated June 1, 2013, revealed the resident was to receive 1000 cubic centimeters (cc's) daily, with an additional 30 cc's of water with each medication administration. This reflected an increase in his daily fluid intake "to lower" his blood urea nitrogen (BUN) levels.</p> <p>On June 6, 2013, at approximately 4:10 p.m., interview with the administrative nurse (Staff #6) confirmed that Resident #3 was to only receive 30 cc's with his medications. At 4:18 p.m., the evening medication nurse (Staff #5) arrived and asked for feedback regarding observations made the previous evening. When discussing Resident #3's water, Staff #5 confirmed the resident had been given 8 oz. (240 cc's) with his medications. She indicated that she routinely gave him the 8 oz., explaining that 30 cc's might not be enough volume to ensure he swallowed all of his medications. When asked, she acknowledged that she had not brought her concerns about this issue to the attention of her supervisors or the primary care physician (PCP).</p> <p>It should be noted that on June 7, 2013, at approximately 2:05 p.m., Staff #6 presented a new telephone order from the PCP, dated June 7, 2013 that reflected "May give an additional 30 cc's, up to 60 cc's with each med pass to assist with swallowing medications safely."</p> <p>It should be further noted that on June 7, 2013, at approximately 1:55 p.m., the facility's special</p>	I 500		

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I 500	<p>Continued From page 14</p> <p>projects officer (Staff #3) stated that she could find no documented evidence that their medication nurses had received training on Resident #3's fluid restriction orders, to include the 30 cc's given with medications.</p> <p>B. The facility's nursing services failed to ensure that the direct support staff received effective training on Resident #3's fluid restriction, as follows:</p> <p>On June 7, 2013, at approximately 1:15 p.m., review of monthly charts on which staff documented the amount of fluids Resident #3 received at his meals and snacks revealed that on May 3, 2013, staff documented that he received 1448 cc's fluids that day. On both June 5 and on June 6, 2013, staff documented that he received 1100 cc's fluids. The resident's POS, however, limited his daily fluid intake to 1000 cc's at meals and snacks. On June 7, 2013, at approximately 1:50 p.m., Staff #3 presented a signature sheet, dated April 23, 2013, that documented that the qualified intellectual disabilities professional (QIDP, Staff #1) had trained 17 staff on the resident's mealtime protocol, including his fluid restriction orders. Documentation maintained by staff on May 3, 2013, June 5, 2013 and June 6, 2013 indicated that the training had not been effective.</p> <p>C. Review of Resident #3's nursing records and fluid intake sheets revealed no evidence the consulting registered nurse (RN, Staff #4 Crum) had reviewed his fluid intake data. On June 7, 2013, at 12:55 p.m., review of the contract between the facility and Staff #4, signed September 3, 2012, revealed she was to "supervise the licensed practical nurses and medication pass" and "maintain a deficiency-free</p>	I 500		

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I 500	<p>Continued From page 15</p> <p>nursing program." At 4:45 p.m., the QIDP attempted to reach Staff #4 by telephone; however, there was no opportunity presented to interview her before the survey ended at 5:15 p.m.</p> <p>There was no evidence that the facility's medical team, to include the primary care physician, had established and implemented a system of oversight to ensure compliance with the 1000+30+30= 1060 cc's per day fluid restriction, to achieve the desired outcome.</p> <p>III. [483.420(a)(11)] The GHIID failed to ensure Resident #3's right to participate in community outings/ recreational activities of choice, as follows:</p> <p>On June 5, 2013, at 5:40 p.m., an onsite interview with Resident #3's mother in the facility revealed that her son's two favorite things to do during leisure time was to go bowling and to play with / manipulate pieces of Lego building blocks. The resident's mother stated that she thought he went bowling once a week.</p> <p>On June 6, 2013, at approximately 1:50 p.m., interview with the house manager (Staff #2) revealed that "everyone" went duckpin bowling. Review of Resident #3's community outings and recreational activity records for the period January 2013 - June 2013 revealed staff had documented two bowling trips during the 6 months: once in January and once in March. His Activities Calendar, however, reflected bowling on every Wednesday and his Individual Support Plan, dated March 29, 2013, reflected "on Wednesdays, I go... bowling." At 2:24 p.m., follow-up interview with Staff #2 revealed that bowling leagues sometimes used the lanes on</p>	I 500		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2013
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE 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 500	Continued From page 16 Wednesdays and the facility had not explored going on other evenings.	I 500		