

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

PRINTED: 07/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012	
NAME OF PROVIDER OR SUPPLIER COMP CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from June 20, 2012 through June 22, 2012. A sample of three clients was selected from a population of five men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and at three day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000	<p><i>Received 7/15/12</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of each client, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On June 21, 2012, at 9:52 a.m., Client #1 was observed seated at his day program. His head was down, chin to his chest and his eyes were closed. During the observation period, the client occasionally opened his eyes when staff spoke to</p>	W 120		

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

John Jenkins

TITLE

Administrator

(X6) DATE

7/19/12

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>him or gave him a gentle touch to his shoulder; otherwise, he mostly kept his head down, eyes closed and ignored staff. At 10:07 a.m., Client #1's day program primary direct support staff (DP1), who said she had worked with him for 3 years, stated that the client had "been like this all morning...been a change in the past few weeks." At 10:45 a.m., the day program nurse (DPN1) and another direct support staff (DP2) took the client to the men's room. Upon his return to the treatment room, at 10:47 a.m., Client #1 sat with his eyes open, stared at the table in front of him and did not respond to DP2's attempts to engage him in an activity. By 11:01 a.m., the client had closed his eyes again and resumed his previous position.</p> <p>At 12:19 p.m., another day program direct support staff (DP3) spoke into Client #1's ear. The client immediately declared in a loud voice "I don't feel good!" A moment later, another day program staff, who was seated at the table, (DP4) asked the client if he wanted food. He repeated loudly "I don't feel good" and then tried to stand up on his own. Staff asked him to remain seated while DP2 retrieved his walker. DPN1 arrived as DP2 returned with the walker. She and other staff interacted with the client until DP3 and DP4 assisted the client to a restroom at 12:30 p.m. Upon return from the restroom, the client refused to eat his lunch. [Note: Eventually, the lunch plate was removed, the food uneaten. DPN1 indicated that it would be reheated and offered to him again at a later time.]</p> <p>At 12:38 p.m., interview with DPN1 revealed that Client #1 was known to say he doesn't feel well "if he has stomach distress." DP1 stated the same</p>	W 120		

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W 120 Continued From page 2
at 1:09 p.m., adding that if he complains of not feeling well, she will alert the nurse, who checks his vital signs and assesses his abdomen. DPN1, who was present at the time, confirmed this was the established protocol. DPN1 further indicated that she had not been informed by staff that day that Client #1 had complained he did not feel well. She had not, therefore, assessed him. The client was no assessed before this surveyor brought the issue to the DPN's attention. According to DP1 and DPN1, the staff (DP3) who elicited the first "I don't feel good" statement had worked with Client #1 for some time and "should have told" DPN1 of the client's complaint.

On June 21, 2012, Client #1's day program staff failed to report to the nurse his complaints of not feeling well.

It should be noted that at 1:27 p.m. DPN1 assessed Client #1. After checking his vital signs, she reported that his abdomen was soft and returned him to his active treatment room.

When interviewed on June 21, 2012, at 4:10 p.m., the qualified intellectual disabilities professional (QIDP) nodded (affirmatively) when informed that the day program nurse expected day program direct support staff to inform him if Client #1 had any health or wellness complaints. The QIDP indicated that he would follow-up with the day program to ensure that all staff received appropriate training.

W 120

<p>W 120</p> <ul style="list-style-type: none"> - A meeting was held at Client #1's day program on 07//17/12 to discuss the deficiencies. Emphasis of the meeting was the subject of staff notifying the day program's nurse in a timely fashion on issues of medical needs of all clients. 	<p>07/17/12</p>
<ul style="list-style-type: none"> - Day program staff will be trained on timeliness of reporting of medical needs of all clients. 	<p>07/23/12</p>

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a

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W 159 Continued From page 4
then observed taking small, hesitant steps, with long pauses in between. After a 2-minute pause, the QIDP was heard telling him "Don't be scared." The client then continued walking slowly approximately 5 feet to a loveseat in the living room, with the QIDP's right arm hooked under Client #1's left arm for support. Throughout the remainder of the survey, Client #1 was observed receiving various degrees of staff assistance while ambulating with the rolling walker.

1. On June 21, 2012, beginning at 3:24 p.m., review of Client #1's physical therapy (PT) records revealed annual PT evaluations dated July 10, 2011 and June 12, 2012. The evaluation report dated June 12, 2012 indicated the "brakes on his Rollator need to be adjusted." The PT recommended having the brakes adjusted or replaced. When the QIDP was asked about the brakes, at 3:45 p.m., he indicated he was previously unaware of the PT's brake-related concerns or recommendations and that, to date, no action had been taken to have them fixed.

[Note: During the course of the aforementioned interview, the QIDP telephoned the facility's corporate office. At 3:48 p.m., he reported that a second Rollator would be purchased and brought to the facility on the following day. He further stated that the brakes on the first Rollator would be fixed; Client #1 would therefore have two walkers available in the future.]

2. On June 22, 2012, at 2:45 p.m., review of monthly nursing summary reports in Client #1's record revealed Client #1 began using the Rollator walker some time in March 2012 (date not specified). The client's records failed to show

W 159

W 159 (1)

- This is a complete misrepresentation of the QIDP's statement pertaining to the recommendation by the PT to get the brakes on the Roller adjusted. The QIDP was aware of the recommendation and did point to the surveyor that the maintenance division of CCII has been scheduled to fix one the brakes. The QIDP also further stated that another Roller has been ordered so that Client #2 can have a second Roller while the other is fixed.
- It is to be noted that the PT visited the home on June 12th, 2012 to assess Client #1 and others. The report of Client #1 was received on June 18th. The certification started on June 20th, 2012 by then the request had been made to the maintenance division of CCII to fix the brakes on the Roller, and an order for a second Roller had already been placed.

06/23/12

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W 159 Continued From page 3 qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination, monitoring, and implementation of each client's habilitation and planning, for one of the three sampled clients. (Client #1)

W 159

W 159 (4)

- All Direct Support Staff, the QIDP, House Manager, and Client #1 will be trained by the PT on the safe and proper use of the Roller, and fall prevention techniques.
- Staff training and training of Client #1 will be done semi-annually or as needed.

07/24/12

The findings include:

On June 20, 2012, at 3:36 p.m., Client #1 was observed entering the facility. Staff lifted his rolling walker over the front door threshold while other staff assisted him to walk through the doorway. Once inside, the client sat on the walker and staff pushed him to a restroom located in the hallway leading towards the kitchen. At approximately 5:10 p.m., the qualified intellectual disabilities professional (QIDP) stated that he and staff had observed significant changes in Client #1's physical and mental abilities beginning "a few months" before the survey. A rolling walker was then purchased, the physical therapist assessed the client, as did the occupational therapist. The QIDP further stated that additional diagnostic evaluations were scheduled, after which he would hold a case conference with the client's interdisciplinary team.

On June 20, 2012, at 5:19 p.m., a direct support staff (S1) was observed steadying Client #1 after the client stood up at the dining room table. The client took both handles on a rolling walker while the qualified intellectual disabilities professional (QIDP) held the walker steady. The client was

W 159 (5)

- A new tracking form for the monitoring of adaptive equipment including the Roller has been put in place. Staff have been trained on tracking of adaptive equipment.
- The facility's House Manager will on a monthly basis review all adaptive tracking records to ensure that adaptive equipment are consistently tracked monthly by staff.

07/15/12
07/31/12

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W 159	<p>Continued From page 5</p> <p>evidence that the walker had been assessed by the PT prior to June 12, 2012, to ensure it was safe and would meet the client's needs. As noted above, the brakes were not functioning properly at that time.</p> <p>3. Review of Client #1's PT, nursing and habilitation records on June 21, 2012 and June 22, 2012 failed to show evidence that the client had received training by the PT (or any clinician) on the safe and proper use of the Rollator walker since use of the walker was initiated three months earlier.</p> <p>4. On June 22, 2012, at approximately 1:10 p.m., review of the facility's staff in-service training records revealed no evidence that staff had received training on the safe and proper use of the walker, or in fall prevention techniques in the months since he began showing decreased strength and abilities, to ensure Client #1's safety while ambulating.</p> <p>5. On June 22, 2012, at 2:15 p.m., review of the facility's Adaptive Equipment Book revealed that the most recent documentation recorded by facility staff regarding the condition of Client #1's adaptive equipment was dated July 5, 2011. Those records reflected a daily tracking of his eye glasses and hearing aid, but not the Rollator walker (purchased in March 2012). The house manager was present at the time of said review. She stated that staff still were expected to maintain daily documentation of the client's adaptive equipment. At 2:18 p.m., she acknowledged there was no documentation regarding Client #1's adaptive equipment for the past 11 months.</p>	W 159	<p>W 159 (2)</p> <ul style="list-style-type: none"> - The brakes on the Roller were fixed by the maintenance division of CCII on June 23, 2012. - A second Roller for Client #2 was delivered to CCII on June 27, 2012. Please see receipt herewith. Client #1 now has two Rollers all in good working condition. <p>W 159 (3)</p> <ul style="list-style-type: none"> - The Roller was purchased in March 2012. The PT assessed the Roller to ensure the appropriate use by Client #1 on June 12, 2012 and will reassess the repaired Roller, and the newly purchased Roller on July 24, 2012. - In the future, all adaptive equipment will be assessed by the prescribing clinician prior to use by the clients. - The PT will be following-up with Client #1 quarterly or as needed to evaluate the status of the Roller and PT needs. 	<p>06/27/12</p> <p>07/15/12</p> <p>07/24/12</p>

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W 159	Continued From page 6 There was no evidence that the QIDP coordinated and monitored Client #1's adaptive equipment and PT training needs timely. It should be noted that the QIDP was not onsite and therefore unavailable for follow-up interview on June 22, 2012.	W 159	
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 all drugs were administered without error, for one of the five clients residing in the facility. (Client #2) The finding includes: The morning medication administration was observed on June 21, 2012. At 7:50 a.m., Client #2 was administered his medications, including Levothyroxine 112 mcg. Staff stated that the client had finished eating his breakfast just moments prior to receiving his medications. On June 21, 2012, at 9:05 a.m., review of Client #2's physician orders sheets (POS) dated June 1, 2012, revealed the following: "Levothyroxine 112 mcg (WF: Synthroid) Take one tablet by mouth every morning half hour before or 2 hours after food for hypothyroidism." The medication administration record showed the Synthroid was scheduled for a 7 a.m. administration daily. At	W 369	<p>W 369</p> <ul style="list-style-type: none"> - At 9:10am, the facility's Licensed Practical Nurse (LPN) followed up with the primary care physician in the presence of the surveyor pertaining to the correct order for the Levothyroxine 112 mcg (WF: Synthroid). The primary care physician clarified the order as "Levothyroxine 112 mcg (WF: Synthroid) daily at 7am." Given that the order was clarified as "daily at 7a.m.," a medication error was not committed since Synthroid was administered during the 7a.m. meds pass. - However, the facility's Registered Nurse (RN) will on a monthly basis review all medical records to ensure that orders are consistent across records and adhered to by nurses. <p>06/22/12</p> <p>07/31/12</p>

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W 369 Continued From page 7
9:21 a.m., the nurse who had administered the morning medications acknowledged that 2 hours had not passed before she administered Client #2 his Synthroid. She then indicated that she would follow-up with the client's primary care physician.

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.

W 436

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to establish a system to ensure each client's adaptive equipment was maintained in good repair and clients received training on the proper use of equipment, for one of the three clients in the sample. (Client #1)

The finding includes:

On June 20, 2012, at 5:19 p.m., a direct support staff (S1) was observed steadying Client #1 after the client stood up at the dining room table. The client took both handles on a rolling walker while the qualified intellectual disabilities professional (QIDP) held the walker steady. The client was then observed taking small, hesitant steps, with long pauses in between. After a 2-minute pause, the QIDP was heard telling him "Don't be scared." The client then continued walking slowly approximately 5 feet to a loveseat in the living room, with the QIDP's right arm hooked under

W 436 (1)	
- The brakes on the Roller were adjusted by the maintenance division of CCII on June 23, 2012.	
- A second Roller for Client #2 was delivered to CCII on June 27, 2012. Please see receipt herewith. Client #1 now has two Rollers all in good working condition.	07/15/12
- In the future, all adaptive equipment will be assessed by the prescribing clinician prior to use by the clients.	07/24/12
- The PT will be following-up with client #1 quarterly or as needed to evaluate the status of the Roller and PT needs.	07/24/12

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W 436	Continued From page 8 Client #1's left arm for support. 1. On June 21, 2012, beginning at 3:24 p.m., review of Client #1's physical therapy (PT) records revealed annual PT evaluations dated July 10, 2011 and June 12, 2012. The evaluation report dated June 12, 2012 indicated the "brakes on his Rollator need to be adjusted." The PT recommended having the brakes adjusted or replaced. When the QIDP was asked about the brakes, at 3:45 p.m., he indicated he was previously unaware of the PT's brake-related concerns or recommendations and that, to date, no action had been taken to have them fixed. 2. Review of Client #1's PT, nursing and habilitation records on June 21, 2012 and June 22, 2012 failed to show evidence that the client had received training by the PT (or any clinician) on the safe and proper use of the Rollator walker since use of the walker was initiated three months earlier. 3. On June 22, 2012, at 2:15 p.m., review of the facility's Adaptive Equipment Book revealed that staff failed to maintain daily documentation of the client's adaptive equipment which was acknowledged by the house manager at 2:18 p.m. It should be noted that the QIDP was not onsite and therefore unavailable for follow-up interview on June 22, 2012.	W 436	<p>W 436 (2)</p> <ul style="list-style-type: none"> - All Direct Support Staff, the QIDP, House Manager, and Client #1 will be trained by the PT on the safe and proper use of the Roller, and fall prevention techniques. - Staff training and training of Client #1 will be done semi-annually or as needed. 	07/24/12	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	<p>W 436 (3)</p> <ul style="list-style-type: none"> - A new tracking form for the monitoring of adaptive equipment, including the Roller has been put in place. Staff have been trained on tracking of adaptive equipment. - The facility's House Manager will on a monthly basis review all adaptive tracking records to ensure that adaptive equipment are consistently tracked monthly by staff. 	07/15/12 07/31/12	

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W 455 Continued From page 9

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure effective infection control procedures were implemented, for one of the five clients residing in the facility. (Client #4)

The finding includes:

On June 20, 2012, beginning at 4:05 p.m., Client #4 was observed to place his left hand in the front and back of his pants while lying on the living room floor. At 4:41 p.m., Client #4 was again observed with his left hand in the back and front his pants. Continue observations revealed Client #4 remain seated and lying on the living room floor until approximately 5:35 p.m. The client was then escorted to the dining table by Staff #1. At 5:40 p.m., the client was served baked sole file, mash potatoes, mixed vegetables, corn bread, and a beverage family style, for dinner. Client #4 was not observed to wash his hands prior to eating.

On June 22, 2012, at approximately 1:45 p.m., a telephone interview was conducted with Staff #1 (who was assigned to Client #4) on June 20, 2012. According to Staff #1, he confirmed that Client #4 did not wash his hands prior to eating dinner. Staff #1 then added that he would make sure that Client #4 washes his hands prior to snack and dinner from this point on.

At the time of the survey, the facility failed to ensure that Client #4 washed his hands prior to eating dinner.

W 474 483.480(b)(2)(iii) MEAL SERVICES

W 455

<p>W 455</p> <ul style="list-style-type: none"> - Staff have been trained on infection control measures. 	<p>07/15/12</p>
<ul style="list-style-type: none"> - Client #4 has a program plan in place to support him in completing the steps of hand washing. 	<p>07/30/12</p>
<ul style="list-style-type: none"> - The facility's House Manager will, on a weekly basis monitor staff during meal preparation and serving to ensure that infection control measures are adhered to. 	<p>07/30/12</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
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NAME OF PROVIDER OR SUPPLIER COMP CARE II	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011
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W 474 Continued From page 10

Food must be served in a form consistent with the developmental level of the client.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that clients received food in a form consistent with their developmental levels, for one the three clients included in the sample. (Client #3)

The finding includes:

The facility failed to ensure that Client #3's food was served in a finely chopped consistency.

On June 20, 2012, at 3:40 p.m. the house manager (HM) placed a choice of apples, applesauce, and yogurt in front of Client #3 during snack time. The client refused his snack. At 3:47 p.m., Client #3 was offered a snack again by Staff #1 who was assigned to the client. At 3:50 p.m., the client was observed to have some difficulty with taking the initial bite of the apple because of some observed missing teeth. Continued observations revealed the client was able to chew and swallow the remainder of the apple without difficulty. At 5:47 p.m., Staff #2 presented Client #3 with his dinner, which consisted of finely chopped baked sole file, mixed vegetables, corn bread and mash potatoes. At approximately 6:00 p.m., interview with Staff #1 revealed that Client #3 was prescribed a finely chopped firm meats and vegetables diet. When asked about the snack, Staff #1 replied by saying, Client #3's apple should have been finely chopped.

W 474

W 474

- The facility's nutritionist has in-serviced all staff on issues pertaining to food textures, portion control, and diet type.
- The facility's House Manager will on a monthly basis observe staff during meal preparation and serving to ensure compliance with diet orders.
- Staff will be trained semi-annually by the nutritionist on areas such as diet type, texture, portion control, and food choices.

07/15/12

07/30/12

07/30/12

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

PRINTED: 07/09/2012
FORM APPROVED
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W 474 Continued From page 11

Interview with the licensed practical nurse #1 (LPN) on June 22, 2012, approximately 1:20 p.m., revealed that she did observe Client #3 eating the entire apple on June 20, 2012. LPN #1 stated that the apple should have been chopped. At approximately 2:00 p.m., interview with the HM revealed that she was aware that Client #3's apple was not served as prescribed.

On June 22, 2012, at 10:24 a.m., review of Client #3's a mealtime guideline (MG) dated April 10, 2012, revealed, the client had an isolated edentulous area on the upper dental arch which impacted his proper mastication of food during meals. Further review of the MG revealed the client was prescribed a finely chopped diet.

W 474

Health Regulation & Licensing Administration

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I 000 INITIAL COMMENTS

I 000

A licensure survey was conducted from June 20, 2012 through June 22, 2012. A sample of three residents was selected from a population of five men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at three day programs, interviews with 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.]

I 042 3502.2(b) MEAL SERVICE / DINING AREAS

I 042

Modified diets shall be as follows:

(b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...

This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that modified diets were served as prescribed, for one of the three residents included in the sample. (Resident #3)

The finding includes:

The GHPID failed to ensure that Resident #3's food was served in a finely chopped consistency.

On June 20, 2012, at 3:40 p.m. the house

Health Regulation & Licensing Administration

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

TITLE *Adm. Asst.*

(X6) DATE *7/19/12*

Health Regulation & Licensing Administration

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I 042	Continued From page 1 manager (HM) placed a choice of apples, applesauce, and yogurt in front of Resident #3 during snack time. The resident refused his snack. At 3:47 p.m., Resident #3 was offered a snack again by Staff #1 who was assigned to the resident. At 3:50 p.m., the resident was observed to have some difficulty with taking the initial bite of the apple because of some observed missing teeth. Continued observations revealed the resident was able to chew and swallow the remainder of the apple without difficulty. At 5:47 p.m., Staff #2 presented Resident #3 with his dinner, which consisted of finely chopped baked sole filet, mixed vegetables, corn bread and mash potatoes. At approximately 6:00 p.m., interview with Staff #1 revealed that Resident #3 was prescribed a finely chopped firm meats and vegetables diet. When asked about the snack, Staff #1 replied by saying, Resident #3's apple should have been finely chopped. Interview with the licensed practical nurse #1 (LPN) on June 22, 2012, approximately 1:20 p.m., revealed that she did observe Resident #3 eating the entire apple on June 20, 2012. LPN #1 stated that the apple should have been chopped. At approximately 2:00 p.m., interview with the HM revealed that she was aware that Resident #3's apple was not served as prescribed. On June 22, 2012, at 10:24 a.m., review of Resident #3's a mealtime guideline (MG) dated April 10, 2012, revealed, the resident had an isolated edentulous area on the upper dental arch which impacted his proper mastication of food during meals. Further review of the MG revealed the resident was prescribed a finely chopped diet.	I 042	<div style="border: 1px solid black; padding: 5px;"> <p>I 042</p> <ul style="list-style-type: none"> - The facility's nutritionist has in-serviced all staff on issues pertaining to food textures, portion control, and diet type. - The facility's House Manager will on a monthly basis observe staff during meal preparation and serving to ensure compliance with diet orders. - Staff will be trained semi-annually by the nutritionist on areas such as diet type, texture, portion control, and food choices. </div>	07/15/12 07/30/12 07/30/12
I 075	3503.3(d) BEDROOMS AND BATHROOMS	I 075		

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I 090 Continued From page 3

I 090

This Statute is not met as evidenced by:
Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observation, for three of the five residents of the facility. (Residents #2, #3, and #5)

The findings include:

1. During the inspection of the environment on June 21, 2012, at 3:10 p.m., there was a broken space heater observed leaning awkwardly against a corner in Resident #2's bedroom. The house manager (HM), who was present at the time, stated that a fire marshall had instructed them to remove the space heater from the office in the basement. She further indicated that GHPID staff were to have taken the broken heater up to the attic for indefinite storage.

2. On June 21, 2012, at 3:18 p.m., the caulking around a bathtub located in the upstairs hallway (used by Residents #2, #3 and #5) was cracked, with black and brown mold and mildew stains and, therefore, was in need of repair.

I 090, 1

- The broken heater has been removed and stored in the attic.

06/24/12

I 090, 2

- The caulking has been repaired.

- The facility's maintenance division will on a monthly basis conduct internal and external environmental audits to ensure compliance with Statue I090

06/24/12

07/30/12

I 180 3508.1 ADMINISTRATIVE SUPPORT

I 180

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 persons with intellectual disabilities (GHPID) failed to ensure

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I 180	Continued From page 4 that the qualified intellectual disabilities professional (QIDP) coordinated and monitored adaptive equipment and physical therapy needs timely, for one of the three residents in the sample. (Resident #1) The findings include: On June 20, 2012, at 3:36 p.m., Resident #1 was observed entering the facility. Staff lifted his rolling walker over the front door threshold while other staff assisted him to walk through the doorway. Once inside, the resident sat on the walker and staff pushed him to a restroom located in the hallway leading towards the kitchen. At approximately 5:10 p.m., the qualified intellectual disabilities professional (QIDP) stated that he and staff had observed significant changes in Resident #1's physical and mental abilities beginning "a few months" before the survey. A rolling walker was then purchased, the physical therapist assessed the resident, as did the occupational therapist. The QIDP further stated that additional diagnostic evaluations were scheduled, after which he would hold a case conference with the resident's interdisciplinary team. On June 20, 2012, at 5:19 p.m., a direct support staff (S1) was observed steadying Resident #1 after the resident stood up at the dining room table. The resident took both handles on a rolling walker while the qualified intellectual disabilities professional (QIDP) held the walker steady. The resident was then observed taking small, hesitant steps, with long pauses in between. After a 2-minute pause, the QIDP was heard telling him "Don't be scared." The resident then continued walking slowly approximately 5 feet to a loveseat in the living room, with the QIDP's right arm	I 180	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 5px;">I 180 - A case conference is scheduled for July 26, 2012 to discuss changes in Resident#1's physical and mental status.</td> <td style="width:20%; text-align: center; vertical-align: middle;">07/26/12</td> </tr> <tr> <td colspan="2" style="height: 100px;"> </td> </tr> <tr> <td style="padding: 5px;">I 180, 1 - Cross Reference W436 (1)</td> <td style="text-align: center; vertical-align: middle;">06/23/12</td> </tr> </table>	I 180 - A case conference is scheduled for July 26, 2012 to discuss changes in Resident#1's physical and mental status.	07/26/12			I 180, 1 - Cross Reference W436 (1)	06/23/12
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I 180, 1 - Cross Reference W436 (1)	06/23/12								

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I 180 Continued From page 5

hooked under Resident #1's left arm for support. Throughout the remainder of the survey, Resident #1 was observed receiving various degrees of staff assistance while ambulating with the rolling walker.

1. On June 21, 2012, beginning at 3:24 p.m., review of Resident #1's physical therapy (PT) records revealed annual PT evaluations dated July 10, 2011 and June 12, 2012. The evaluation report dated June 12, 2012 indicated the "brakes on his Rollator need to be adjusted." The PT recommended having the brakes adjusted or replaced. When the QIDP was asked about the brakes, at 3:45 p.m., he indicated he was previously unaware of the PT's brake-related concerns or recommendations and that, to date, no action had been taken to have them fixed.

[Note: During the course of the aforementioned interview, the QIDP telephoned the facility's corporate office. At 3:48 p.m., he reported that a second Rollator would be purchased and brought to the facility on the following day. He further stated that the brakes on the first Rollator would be fixed; Resident #1 would therefore have two walkers available in the future.]

2. On June 22, 2012, at 2:45 p.m., review of monthly nursing summary reports in Resident #1's record revealed Resident #1 began using the Rollator walker some time in March 2012 (date not specified). The resident's records failed to show evidence that the walker had been assessed by the PT prior to June 12, 2012, to ensure it was safe and would meet the resident's needs. As noted above, the brakes were not functioning properly at that time.

3. Review of Resident #1's PT, nursing and

I 180

<p>I 180, 2</p> <ul style="list-style-type: none"> - The Roller was purchased in March 2012. The PT assessed the Roller to ensure the appropriate use by Client #1 on June 12, 2012 and will reassess the repaired Roller, and the newly purchased Roller on July 24, 2012. 	<p>07/26/12</p>
<ul style="list-style-type: none"> - In the future, all adaptive equipment will be assessed by the prescribing clinician prior to use by the clients. 	<p>07/24/12</p>
<ul style="list-style-type: none"> - The PT will be following-up with Client #1 quarterly or as needed to evaluate the status of the Roller and PT needs 	<p>07/24/12</p>

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I 180 Continued From page 6

habilitation records on June 21, 2012 and June 22, 2012 failed to show evidence that the resident had received training by the PT (or any clinician) on the safe and proper use of the Rollator walker since use of the walker was initiated three months earlier.

4. On June 22, 2012, at approximately 1:10 p.m., review of the facility's staff in-service training records revealed no evidence that staff had received training on the safe and proper use of the walker, or in fall prevention techniques in the months since he began showing decreased strength and abilities, to ensure Resident #1's safety while ambulating.

5. On June 22, 2012, at 2:15 p.m., review of the facility's Adaptive Equipment Book revealed that the most recent documentation recorded by facility staff regarding the condition of Resident #1's adaptive equipment was dated July 5, 2011. Those records reflected a daily tracking of his eye glasses and hearing aid, but not the Rollator walker (purchased in March 2012). The house manager was present at the time of said review. She stated that staff still were expected to maintain daily documentation of the resident's adaptive equipment. At 2:18 p.m., she acknowledged there was no documentation regarding Resident #1's adaptive equipment for the past 11 months.

It should be noted that the QIDP was not onsite and therefore unavailable for follow-up interview on June 22, 2012.

I 180

I 180, 3

- All Direct Support Staff, the QIDP, House Manager, and Client #1 will be trained by the PT on the safe and proper use of the Roller, and fall prevention techniques.
- Staff training and training of Client #1 will be done semi-annually or as needed.

07/24/12

I 180, 4

- Cross reference I 180, 3

07/24/12

I 180, 5

- Cross Reference W436 (3)

07/15/12

I 206 3509.6 PERSONNEL POLICIES

I 206

Each employee, prior to employment and annually thereafter, shall provide a physician ' s

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I 206	<p>Continued From page 7</p> <p>certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for 1 out of 4 nurses and 2 of the 10 consultants. (LPN2, C1 and C2)</p> <p>The findings include:</p> <p>On June 22, 2012, beginning at 9:05 a.m., review of the personnel records revealed the following:</p> <ol style="list-style-type: none"> 1. There was no evidence of a physician's health inventory/ certificate for LPN2. 2. There was no evidence of a physician's health inventory/ certificate for the behavior specialist (C1). 3. There was documentation that the nutritionist (C2) had received a tuberculosis screening on May 1, 2012. There was no evidence, however, of a comprehensive physician's health inventory/ certificate. <p>On June 22, 2012, at 11:45 a.m., an administrative staff (S2) acknowledged there was no evidence of health inventories performed by a physician for the aforementioned personnel. She stated she would seek additional information from their corporate office. No additional information</p>	I 206	<p>I 206</p> <ul style="list-style-type: none"> - LPN2, behavior specialist (C1), and the nutritionist (C2) have submitted the complete required documents. - The monitoring tracking and tracking of personnel, and consultant records will be relinquished from the assistant administrator and delegated to a program coordinator who will be responsible to ensure that all personnel records are comprehensive and submitted in a timely manner. - Quarterly audits of personnel and consultant records will be done quarterly by a Quality Assurance (QA) staff to ensure compliance with Statue 206. 	<p>06/23/12</p> <p>07/31/12</p> <p>07/31/12</p>
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I 206 Continued From page 8
was presented before the survey ended at 2:43 p.m.

This is a repeat deficiency. See Licensure Deficiency Report dated July 20, 2012.

I 206

I 229 3510.5(f) STAFF TRAINING

Each training program shall include, but not be limited to, the following:

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that staff received training on residents' physical therapy/ ambulation safety needs, for one of the three residents in the sample. (Resident #1)

The finding includes:

On June 20, 2012, at 3:36 p.m., Resident #1 was observed entering the facility. Staff lifted his rolling walker over the front door threshold while other staff assisted him to walk through the doorway. Once inside, the resident sat on the walker and staff pushed him to a restroom located in the hallway leading towards the kitchen. At approximately 5:10 p.m., the qualified intellectual disabilities professional (QIDP) stated that he and staff had observed significant changes in Resident #1's physical and mental abilities beginning "a few months" before the survey. A rolling walker was then purchased, the

I 229

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I 229 Continued From page 9

physical therapist assessed the resident, as did the occupational therapist. The QIDP further stated that additional diagnostic evaluations were scheduled, after which he would hold a case conference with the resident's interdisciplinary team.

At 5:19 p.m., a direct support staff (DSP1) was observed steadying Resident #1 after the resident stood up at the dining room table. The resident took both handles on the walker while the QIDP held the walker steady. The resident was then observed taking small, hesitant steps, with long pauses in between. After a 2-minute pause, the QIDP was heard telling him "Don't be scared." The resident then continued walking slowly approximately 5 feet to a loveseat in the living room, with the QIDP's right arm hooked under Resident #1's left arm for support. Throughout the remainder of the survey, Resident #1 was observed receiving various degrees of staff assistance while ambulating with the rolling walker.

1. On June 22, 2012, at 2:45 p.m., review of monthly nursing summary reports in Resident #1's record revealed Resident #1 began using the Rollator walker some time in March 2012 (date not specified). Review of Resident #1's PT, nursing and habilitation records on June 21, 2012 and June 22, 2012 failed to show evidence that the resident had received training by the PT (or any clinician) on the safe and proper use of the Rollator walker since use of the walker was initiated three months earlier.

2. On June 22, 2012, at approximately 1:10 p.m., review of the facility's staff in-service training records revealed no evidence that staff had received training on the safe and proper use of

I 229

I 229 (1)

- A case conference is scheduled for July 26, 2012 to discuss changes in Resident #1's physical and mental status.
- All Direct Support Staff, the QIDP, House Manager, and Client #1 will be trained by the PT on the safe and proper use of the Roller, and fall prevention techniques.
- Staff training and training of Client #1 will be done semi-annually or as needed.

07/26/12

07/24/12

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(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
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I 229	<p>Continued From page 10</p> <p>the walker, or in fall prevention techniques in the months since he began showing decreased strength and abilities, to ensure Resident #1's safety while ambulating.</p> <p>It should be noted that on June 22, 2012, at 2:15 p.m., review of the facility's Adaptive Equipment Book revealed that the most recent documentation recorded by facility staff regarding the condition of Resident #1's adaptive equipment was dated July 5, 2011. Those records reflected a daily tracking of his eye glasses and hearing aid, but not the Rollator walker (purchased in March 2012). The house manager was present at the time of said review. She stated that staff still were expected to maintain daily documentation of the resident's adaptive equipment. At 2:18 p.m., she acknowledged there was no documentation regarding Resident #1's adaptive equipment for the past 11 months.</p> <p>It should be further noted that the QIDP was not onsite and therefore unavailable for follow-up interview on June 22, 2012.</p>	I 229	<p>I 229 (2)</p> <ul style="list-style-type: none"> - A case conference is scheduled for July 26, 2012 to discuss changes in Resident#1's physical and mental status. - All Direct Support Staff, the QIDP, House Manager, and Client #1 will be trained by the PT on the safe and proper use of the Roller, and fall prevention techniques. - Staff training and training of Client #1 will be done semi-annually or as needed. - A new tracking form for the monitoring of adaptive equipment including the Roller has been put in place. Staff have been trained on tracking of adaptive equipment. - The facility's House Manager will on a monthly basis review all adaptive tracking records to ensure that adaptive equipment are consistently tracked monthly by staff. 	<p>07/26/12</p> <p>07/24/12</p> <p>07/15/12</p> <p>07/31/12</p>
I 379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p>	I 379		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
NAME OF PROVIDER OR SUPPLIER COMP CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011	
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I 379	<p>Continued From page 11</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all incidents that present a risk to residents' health and well-being were reported immediately and in writing to the Department of Health, Health Regulation and Licensing Administration (DOH/HLRA), for one of the three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On June 21, 2012, at 5:04 p.m., review of a nursing progress note dated March 9, 2012, revealed that Client #3 vomited three (3) times and did not tolerate his lunch while at the day program. The primary care physician (PCP) was notified and advised the GHPID to transport the resident to the emergency room (ER). On March 10, 2012, Resident #3 returned back to the GHPID with a diagnosis vomiting. A pre-survey review of incidents reported to the State agency since the previous survey had not shown evidence that the incident was reported in accordance with this regulation.</p> <p>Interview with the facility nurse (LPN1) on June 21, 2012, at approximately 5:10 p.m., revealed that Resident #3 reportedly had vomited a few times and was ordered to be taken to the ER by the PCP. Further interview with LPN1 revealed that she was not sure if an incident report had been generated for the ER visit. The house manager was interviewed on June 22, 2012, at approximately 12:40 p.m., to ascertain whether an incident report had been written for Resident #3's ER visit. She stated that she would have to check with the office. No additional information was presented before the survey ended at 2:43</p>	I 379	<p>I 379</p> <ul style="list-style-type: none"> - Direct Support Staff, and the House Manager have been trained by the facility's Incident Management Coordinator (IMC) on issues pertaining to reporting of incidents to all relevant parties, timely reporting of incidents, and other related incident management policies and procedures. 07/15/12 - The facility's Incident Management Coordinator (IMC) will on a monthly basis review medical and psychosocial records to ensure that all incidents are reported to all relevant parties and in a timely fashion 07/31/12

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I 379	Continued From page 12 p.m.	I 379		