

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

PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012
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W 000 INITIAL COMMENTS

A recertification survey was conducted from August 19, 2013 through August 20, 2013. A sample of two clients was selected from a population of three males and one female, 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 guardian, 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 186 483.430(d)(1-2) DIRECT CARE STAFF

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide sufficient trained staff to implement one to one supervision to one of two clients in the sample. (Client #2)

The finding includes:

W 000

W 186 The facility has identified a one to one trained staff to accompany Client #2 to his day program Monday thru Friday.

9/6/13

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

TITLE

(X8) DATE

Constance A. Reese Program Director 9/18/13

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 186	Continued From page 1 The facility failed to ensure trained relief one to one staff was available to ensure Client #2 was able to attend his day program as scheduled, as evidenced below: On August 19, 2013, at approximately 9:40 a.m., Client #1 was observed walking to the facility van. interview with the house manager (HM #1) revealed that several of the clients had medical appointments, however, Client #1 was going to his day program. HM #1 further stated that the client was scheduled to attend the day program on Monday through Friday. Upon arrival at the day program on August 19, 2013, at 11:55 a.m., the surveyor requested to visit Client #1 in his treatment area. The receptionist responded that Client #1 had not arrived yet, and that the day program had not been informed that he would not be present. interview with the one on one (Staff #1) from the home at 12:12 p.m., revealed the client was late arriving to his day program because two of his housemates had physician's appointments that morning. On August 19, 2013, at 12:08 p.m., interview with Client #2's day program case manager revealed the client was always accompanied to the day program by a one on one staff provided by the home. According to the case manager, the purpose of the one on one staff was to manage the client's targeted behaviors [biting, attempted biting, eating of non-eatable objects (pica)], and to assist with his active treatment. Upon checking the record, on August 19, 2013, at 12:05 p.m., the case manager stated the client attended the day program four days in July 2013 and about the	W 186	The facility will develop a protocol to identify relief staff to work as one to one. This protocol will ensure that two or more staff will be identified and trained to work as a relief staff for Client #2 to accompany him to his day program to avoid frequent absenteeism when his one to one staff is absent from work.	9/27/13	

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W 186	<p>Continued From page 2</p> <p>same number of days in June 2013. The case manager revealed that the client had been absent from the day program due to his helmet being broken, and the lack of an assigned one on one staff to supervise him while at the day program.</p> <p>During interview with the house manager (HM #1) on August 20, 2013, at 2:00 p.m., it was confirmed that Client #2 had attended his day program infrequently during June and July 2013 due to his helmet being broken, and also because his assigned relief one on one staff (8:00 a.m. - 4:00 p.m. shift) had resigned in June 2013. HM #1 stated that the client received a new helmet on July 30, 2013, and now goes to the day program every week day, except when his full time one on one staff is scheduled off duty. According to HM #1, Staff #1 is scheduled off on Thursday and Friday (every other week), prior to his weekend to work. HM #1 revealed that the client remains home on those Thursdays and Fridays because the agency had not been successful in recruiting a part-time one on one staff to replace the staff who resigned from the shift (8:00 a.m.- 4:00 p.m.) in June 2013.</p> <p>On August 20, 2013, at 2:17 p.m., review of records at the home confirmed that the client did not attend his day program seven (7) days in June 2013 and eleven (11) days in July 2013. Further discussion with HM#1 revealed that on Staff #1's days off, Client #2 was monitored by various direct support staff who had been trained on Client #1's behavior support plan, but had not been oriented to supervise the client at his day program. Further inquiry regarding the client's alternative schedule when he did not attend his day program revealed it had not been developed yet.</p>	W 186	<p>The Nursing Staff will order an additional helmet for Client #2 to use when he breaks his helmet. Client #2's adaptive equipment will be monitored weekly by Nursing and Management Staff to ensure that it is in working condition.</p>	9/27/13

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W 186	Continued From page 3 On August 20, 2013, at 3:30 p.m., review of proactive strategies identified in Client #2's behavior support plan (BSP dated May 8, 2013, revealed the facility should "maintain a consistent routine and staffing (1:1/24:7), and set limits and expectations." Further record review revealed staff were trained on Client #2's BSP on July 9, 2013 and July 10, 2013, by qualified Intellectual disabilities professional (QIDP). At the time of the survey, however, the facility failed to ensure that sufficient trained staff was available to manage and supervise Client #1 in accordance with his individual program plan.	W 186			
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, Interview and record review, the facility failed to ensure a comprehensive assessment of the nutritional needs of one of two clients in the sample. (Client #2) The finding includes: The facility failed to ensure a timely and comprehensive nutritional assessment of Client #2's caloric needs, as evidenced below: a. During the observation of the breakfast meal on August 19, 2013, at 7:56 a.m., Client #2 was assisted to eat 100% of a double portion meal. At 12:15 p.m., the client received a double portion	W 217	The facility's Nutritionist will be requested to provide Client #2 with a comprehensive assessment to determine his specific caloric needs to facilitate modification in his current nutritional regime.	9/27/13	

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W 217	<p>Continued From page 4</p> <p>lunch meal and drank a Boost nutritional supplement. Although the one on one (Staff #1) provided assistance to guide the loaded spoonfuls of food to the client's mouth, about half of the food from the plate was spilled onto the floor as the client ate.</p> <p>After returning home from the day program on August 19, 2013, at 4:10 p.m., Client #2 received a fruit bar and water for snack. A few minutes later (4:17 p.m.), Client #2 and his one on one staff went for a walk in the community. Upon returning from the walk at 4:42 p.m., the client appeared agitated, pulled away from his staff, and got on the floor twice, refusing to go upstairs with his one on one staff to be changed. At 4:56 p.m., Client #2 was offered a double portion meal which he rapidly consumed 100% of with handover hand assistance. The client finished the meal at 5:04 p.m., and then went upstairs with his one on one. It should be noted that although the client was observed to receive a large amount of food at all meals and a nutritional supplement during lunch, his body was very lean for his small body frame.</p> <p>b. Interview with the house manager (HM #1) on August 20, 2013, at 2:29 p.m., revealed Client #2 was provided double portions of food at all meals and received eight (8) ounces of Boost nutritional supplement twice a day to help him gain weight. On the same day at 4:40 p.m., interview with Client #2's one on one staff revealed that he usually eats all of his food, however he is very active and also walks a lot in the community.</p> <p>c. On August 20, 2013, at 2:37 p.m., review of the August 2013 physician's orders revealed Client #2 was prescribed a Low fat diet, (extra portions if</p>	W 217	<p>The facility's Primary Care Nurse will review Client #2's current weight chart with the Nutritionist to determine weight gain/loss. Additional training will be provided to staff #1 on how to prevent food spillage using Client #2's adaptive equipment effectively.</p>	9/27/13	

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W 217	<p>Continued From page 5</p> <p>desired, chopped soft foods, finely chopped meats), no concentrated sweets; nutritional supplement one can by mouth two times a day.</p> <p>On August 20, 2013, at 2:45 p.m., Client #2's annual weight record maintained by the nursing staff was reviewed to ascertain the client's weight history during the last twelve months, and revealed that the client's ideal body weight was 112 to 154 pounds. Further review of the chart revealed the following body weights:</p> <ul style="list-style-type: none"> - August 2012 through November 2012: 122 pounds - December 2012: 120 pounds - January 2013 and February 2013: 112 pounds <p>Interview with the facility's nursing staff on August 20, 2013, at 3:32 p.m. revealed that the reason for the eight pound weight difference between December 2012 and January 2013 could not be determined.</p> <p>Note: Review of Client #2's quarterly nutritional assessment dated February 5, 2013 on August 20, 2013, at 2:40 p.m., indicated the client weighed 130.6 pounds (BMI - 20.5); BMI range 18.5 -24.9). The assessment recommended to continue the current nutrition reglme and to reduce the nutritional supplement to two times a week, due to the client's eight pound weight gain during the quarter. At the time of the survey, however, the source of the 130.6 pound weight could not be determined.</p> <p>March 2013 - 114 pounds April 2013 - 116 pounds May 2013 -118 pounds July 2013 - 116 pounds</p>	W 217		

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W 217	Continued From page 6 August 2013 - 114 pounds On August 20, 2013, at 2:48 p.m., review of Client #2's annual nutritional assessment dated May, 5, 2013, revealed he was five feet, seven inches tall, weighed 116 pounds, and that his body mass index (BMI) was 18.2, placing him in the underweight range (based on his desirable body mass index of 18.5 -24.9). Further review of the nutritional assessment revealed a recommendation to continue the low fat, chopped soft food, finely chopped meals, extra portions if desired, provide nutritional supplement two times a day, and monitor weights monthly. At the time survey, there was no evidence that Client #2's weights had been timely and accurately monitored by the nutritionist. Additionally, there was no evidence that Client #2 received a comprehensive nutritional assessment to determine his specific caloric needs to facilitate modification in his nutrition regime, in order to effectively address his weight loss and low body weight.	W 217	The facility's Nutritionist and Primary Care Nurse will monitor Client #2's weight loss and low body weight monthly. The Primary Care Physician will review recommendations from the Nutritionist.	9/27/13	
W 365	483.460(J)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication records were accurately maintained for one of four clients receiving medications. (Client #1) The findings include:	W 365			

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W 365	<p>Continued From page 7</p> <p>1. Observation of the medication administration on August 19, 2013, beginning at 8:20 a.m., revealed Client #1 was observed to receive Aspirin, Calcium, Tegretol, Colace, Fluoxetine, Keppra, Risperdal, Systane and Dorzolamide eye drops from the morning licensed practical nurse (LPN #1).</p> <p>Review of Client #1's medication administration records (MAR) on August 19, 2013, beginning at 10:30 a.m., revealed the following:</p> <ul style="list-style-type: none"> - July 2013 MAR revealed there were no initials documented that indicated the client was administered Systane eye drops on July 12, 2013; - April 2013 MAR revealed there were no initials documented that indicated the client was administered Risperdal, Simvastatin, Docusate, Prozac, Keppra, Aspirin, Calcium, Tegretol, Travalon eye drops, Dorzolamide eye drops and Oxistat skin cream on April 27, 2013; - January 2013, MAR revealed there were no initials documented that indicated the client was administered Keppra, Calcium, Tegretol, Docusate, Travalon and Dorzolamide eye drops on January 12, 2013. Further review revealed there were no initials for Risperdal, Aspirin, Calcium, Tegretol, Docusate, Fluoxetine, Systane and Dorzolamide eye drops on January 21, 2013. There were also no initials documented that indicated the client was administered Calcium on January 13, 2013; - December 2012, MAR revealed there were no initials documented that indicated the client was administered Risperdal, Docusate, Fluoxetine, 	W 365	<p>1. Client #1 frequently visits her family on weekends and her medication is sent home with her family. Nursing Staff will be instructed to document all home visits on the back of her MAR. DON will provide additional training to Nursing Staff on required documentation.</p>	9/27/13	

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W 365	<p>Continued From page 8</p> <p>Keppra, Aspirin, Calcium, Tegretol, Oxistat skin cream, Systane and Dorzolamide eye drops on December 22, 28, 29 and 30, 2012;</p> <p>- November 2012, MAR revealed there were no initials documented that indicated the client was administered Risperdal, Simvastin, Keppra, Calcium, Tegretol, Travaton, Systane and Dorzolamide eye drops on November 24 and 25, 2012. There were also no initials documented that indicated the client was administered Docusate, Fluoxetine and Aspirin on November 25, 2012.</p> <p>Continued review of the MARs for January 2013, May, October and November 2012 on February 7, 2013, revealed that there was no information documented on the back of the MARs to explain why the initials were missing.</p> <p>interview with the registered nurse (RN #1) on August 20, 2013, at 4:51 p.m., revealed that the MAR's required an initial when medication is administered and a written explanation on the back of the MAR's when medication is not given. Further interview revealed Client #1's medications was sent home with the client on the aforementioned dates.</p> <p>2. Observation of the medication administration on August 19, 2013, at 12:17 p.m., at the day program revealed Client #1 was observed to receive Tegretol from the day program licensed practical nurse (LPN #2).</p> <p>Review of Client #1's MAR and his physician's order sheets on August 20, 2013, at 4:51 p.m., revealed the client was prescribed Tegretol three times a day. However, there was no MAR's that</p>	W 365	<p>2. Client #1 receives his noon medication at his day program. The Primary Care Nurse will request that the day program submit the completed MAR back to the facility at the end of each month to be filed. 9/20/13</p>		

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W 365	Continued From page 9 revealed the 12:00 p.m. administration. On August 20, 2013, at 2:45 p.m., interview with RN #1 confirmed that the client receives Tegretol at the day program and that the day program had not been sending the MARs back to the facility. The RN further stated that the facility was required to maintain all MARs, therefore the day program should have been sending the MARs back to the facility.	W 365			
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for two of four clients receiving medications. (Clients #3 and #4) The findings include: During the morning medication administration, the licensed practical nurse (LPN #1) failed to administer medications as prescribed, as follows: 1. On August 19, 2013, beginning at 8:40 a.m., LPN #1 was observed preparing Client #4's medications. At 8:46 a.m., LPN #1 administered two drops of Artificial Tears in each eye. At	W 368			

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W 368	<p>Continued From page 10</p> <p>approximately 11:15 a.m., review of the client's medication administration record (MAR) and physician ' s order sheets (POS) dated August 1, 2013, revealed an order to instill one drop of Artificial Tears in each eye daily.</p> <p>Interview with LPN #1 on August 19, 2013, at approximately 8:50 a.m., revealed she administered two drops of the Artificial Tears in each eye.</p> <p>At the time of the survey, the facility failed to ensure Client #4's Artificial Tears were administered as prescribed by the primary care physician.</p> <p>2. On August 19, 2013, beginning at 8:55 a.m., LPN #1 was observed preparing Client #3's medications. At 9:05 a.m., LPN #1 administered two drops of Artificial Tears in the right eye and one drop in the left eye. At approximately 11:20 a.m., review of the client's medication administration record (MAR) and physician ' s order sheets (POS) dated August 1, 2013, revealed an order to instill one drop of Artificial Tears in each eye daily.</p> <p>Interview with LPN #1 on August 19, 2013, at approximately 8:50 a.m., revealed she administered two drops of the Artificial Tears in the right eye.</p> <p>At the time of the survey, the facility failed to ensure Client #3's Artificial Tears were administered as prescribed by the primary care physician.</p>	W 368	<p>1. LPN #1 will receive training from DON on reviewing POS and MAR before administering eye drops.</p> <p>2. The Primary Care Nurse will make observation of eye drop administration.</p> <p>9/27/13</p>
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369	

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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) COMPLETION DATE
W 369	<p>Continued From page 11</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for two of the four clients receiving medications. (Clients #3 and #4)</p> <p>The findings include:</p> <p>During the morning medication administration, the licensed practical nurse (LPN #1) failed to administer medications without error, as follows:</p> <p>1. On August 19, 2013, beginning at 8:40 a.m., LPN #1 was observed preparing Client #4's medications. At 8:46 a.m., LPN #1 administered two drops of Artificial Tears in each eye. At approximately 11:15 a.m., review of the client's medication administration record (MAR) and physician's order sheets (POS) dated August 1, 2013, revealed an order to instill one drop of Artificial Tears in each eye daily.</p> <p>Interview with LPN #1 on August 19, 2013, at approximately 8:50 a.m., revealed she administered two drops of the Artificial Tears in each eye.</p> <p>At the time of the survey, the facility failed to ensure Client #4's Artificial Tears were administered without error.</p> <p>2. On August 19, 2013, beginning at 8:55 a.m.,</p>	W 369	Cross-reference W368	9/27/13

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

PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

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W 369	Continued From page 12 LPN #1 was observed preparing Client #3's medications. At 9:05 a.m., LPN #1 administered two drops of Artificial Tears in the right eye and one drop in the left eye. At approximately 11:20 a.m., review of the client's medication administration record (MAR) and physician's order sheets (POS) dated August 1, 2013, revealed an order to instill one drop of Artificial Tears in each eye daily. Interview with LPN #1 on August 19, 2013, at approximately 8:50 a.m., revealed she administered two drops of the Artificial Tears in the right eye. At the time of the survey, the facility failed to ensure Client #3's Artificial Tears were administered without error.	W 369			

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 19, 2013 through through August 20, 2013. A sample of two residents was selected from a population of three males and one female, with varying degrees of Intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one residents' guardian, direct support staff, nursing and administrative staff, as well as a review of resident 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>	I 000		
I 090	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with Intellectual disabilities (GHID) failed to maintain the environment in accordance with the needs of four of four residents in the facility. (Residents #1, #2, #3, and #4)</p> <p>The findings include:</p> <p>On August 20, 2013, beginning at 3:40 p.m., the facility's house manager (HM #1) accompanied</p>	I 090	<p>1. The facility will discard the trash can with the hole at the top and purchase a new trash can.</p>	9/12/13

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Constance A. Reese* TITLE *Program Director* / (X6) DATE *9/18/13*

STATE FORM 6899 H-50011 If continuation sheet 1 of 17

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1 090	<p>Continued From page 1</p> <p>the surveyor to conduct an inspection of the environment.</p> <p>a. Observation of one of the two trash cans located in the back yard revealed there was a hole at the top of the can on the right side. Closer observation of the trash can revealed that the top of the can was also warped on the right side, which prevented the lid from tightly covering the trash can. The damaged areas on the trash can created potential entrances for rodents and pests.</p> <p>2. Observation of the stairwell at the basement entrance door revealed numerous flying mosquitos. interview with HM #1 revealed maintenance staff had sprayed the area several times to reduce the flying insects. Further discussion with HM #1 indicated that the spraying had not been effective for a long term reduction of the population of mosquitos, and they always returned. At the time of the survey, the facility failed to identify effective measures to reduce the population of mosquitos in the stairwell leading to the basement entrance door.</p> <p>3. The hinge was broken on the cover of Resident #3's clothes hamper. There was also a large tear on the right side of Resident #2's clothes hamper.</p> <p>4. The front cover for Resident #3's CD cassette player was missing. Further observallon of the interior of the CD cassette player revealed an accumulation of dust. interview with HM #1 at 3:51 p.m., revealed that Resident #3 loved music and used the device daily. At the time of the survey, the facility failed to ensure that Resident #3's CD cassette was maintained in good repair.</p> <p>5. The doors of Resident # 3's wardrobe would</p>	1 090	<p>2. The facility will spray to reduce the number of mosquitos on the stairwell at the basement entrance door. The Maintenance Team will monitor weekly for reduction.</p> <p>3. The Residential Manager has purchased new clothes hampers for Client #2 and #3.</p> <p>4. A new CD Cassette player was purchased for Client #3 and old one was discarded by Residential Manager.</p> <p>5. Client #3's wardrobe cabinet was repaired for doors to fasten securely. Management will monitor weekly to ensure that doors are operable.</p>	<p>9/12/13</p> <p>9/12/13</p> <p>9/12/13</p> <p>9/17/13</p>

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I 090	Continued From page 2 not remain in a closed position. Closer observation of the magnets installed to fasten the doors revealed that they were not operable.	I 090		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to verify that twelve of eighteen employees were provided the opportunity to annually review their written job descriptions as required by this section, for 12 of 17 employees in the facility. [Qualified intellectual disabilities professional (QIDP #1), home manager (HM #1), direct support professionals #1, #2, #3, #4, #5, #6, #7, #8, #9, #10] The finding includes: During the entrance conference on August 19, 2013, at 9:45 a.m., the house manager (HM #1) was notified of the records required to complete the survey process. Record review on August 20, 2013, at beginning at 9:15 a.m., revealed no written verification that that the job descriptions were discussed with each employee at least annually for QIDP #1, HM #1, and direct support professionals #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. At 10:52 a.m., HM#1 was informed of the annual job descriptions reviews that were not available and stated that she would follow-up with the administrative office.	I 203	Annual Job Descriptions will be reviewed and signed by each employee within the facility.	9/20/13

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I 203	Continued From page 3 At the time of the survey exit on August 20, 2013, at 4:45 p.m., no additional job descriptions were provided by the administrative office for the aforementioned staff.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s 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. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each consultants had current health certificates, for one of seven consultants. (Consultant #1) The finding includes: During the entrance conference on August 19, 2013, at 9:45 a.m., the house manager (HM #1) was notified of the records required to complete the survey process. Record review on August 20, 2013, at 10:37 a.m., revealed Consultant #1's health certificate was dated May 29, 2012. HM #1 was requested to inform the administrative office to ascertain if Consultant #1 had a current health certificate on file.	I 206	Health Certificate for Consultant #1 was obtained and filed in his personnel record.	9/6/13

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I 206	Continued From page 4 At the time of the survey exit conference, no updated health certificate was provided for Consultant #1.	I 206	
I 379	3519.10 EMERGENCIES 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. This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that an injury of unknown origin was reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the four residents of the facility. (Resident #3) The finding includes: On August 19, 2013, at 10:44 a.m., review of an unusual incident report dated July 3, 2013 (8:05 a.m.), revealed that a direct support staff noticed an area of discoloration just below Resident #3's left knee, and another mid-way between his knee and ankle. According to the report, the resident was not able to tell the staff how he sustained the	I 379	Notification of all incidents will be made in writing within 24 hours of the next day. The Incident Management Coordinator will provide training to staff on policy and procedures for documenting incidents. 9/2013

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I 379	<p>Continued From page 5</p> <p>discolorations and said he did not know that he had them.</p> <p>Further review of the report revealed that on July 3, 2013, upon notification of the bruises on Resident #3's left leg, the morning medication nurse immediately assessed the resident and administered Tylenol 325 milligram tablet, two tablets for pain. The assessments revealed that the bruised areas were tender to touch, however, there was no bleeding, signs of symptom of infection and the skin was intact. The resident was then referred to director of nursing (DON) #1 who examined the resident and determined no additional findings and recommended no further treatment.</p> <p>interview with the facility's house manager (HM #1) on August 19, 2013, at 11:00 a.m., corroborated the information provided on the incident report.</p> <p>Further review of the unusual incident revealed that the Department of Health (DOH) was notified of Resident #3' injury of unknown origin on July 10, 2013, at 2:00 p.m., seven days after it was discovered, and reported to supervisory staff at the facility.</p> <p>Although the results of the facility's investigative report dated July 15, 2013 revealed that the origin of Resident #3's bruises remained unknown, the facility failed to ensure the the incident was reported to DOH within the time frames established within the regulatory requirements.</p>	I 379	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401	

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I 401	<p>Continued From page 6</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 review, the group home for individuals with intellectual disabilities(GHID)failed to ensure that each individual received professional services in accordance with their needs for three of four residents of the facility. (Resident #2)</p> <p>The findings include:</p> <p>I. The GHID failed to ensure a timely and comprehensive nutritional assessment of Resident #2's caloric needs, as evidenced below:</p> <p>a. During the observation of the breakfast meal on August 19, 2013, at 7:56 a.m., Resident #2 was assisted to eat 100% of a double portion meal. At 12:15 p.m., the resident received a double portion lunch meal and drank a Boost nutritional supplement. Although the one on one (Staff #1) provided assistance to guide the loaded spoonfuls of food to the resident's mouth, about half of the food from the plate was spilled onto the floor as the resident ate.</p> <p>After returning home from the day program on August 19, 2013, at 4:10 p.m., Resident #2 received a fruit bar and water for snack. A few minutes later (4:17 p.m.), Resident #2 and his one on one staff went for a walk in the community. Upon returning from the walk at 4:42 p.m., the resident appeared agitated, pulled away from his staff, and got on the floor twice, refusing</p>	I 401	Cross-reference W217	9/27/13
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I 401	<p>Continued From page 7</p> <p>to go upstairs with his one on one staff to be changed. At 4:56 p.m., Resident #2 was offered a double portion meal which he rapidly consumed 100% of with handover hand assistance. The resident finished the meal at 5:04 p.m., and then went upstairs with his one on one. It should be noted that although the resident was observed to receive a large amount of food at all meals and a nutritional supplement during lunch, his body was very lean for his small body frame.</p> <p>b. interview with the house manager (HM #1) on August 20, 2013, at 2:29 p.m., revealed Resident #2 was provided double portions of food at all meals and received eight (8) ounces of Boost nutritional supplement twice a day to help him gain weight. On the same day at 4:40 p.m., interview with Resident #2's one on one staff revealed that he usually eats all of his food, however he is very active and also walks a lot in the community.</p> <p>c. On August 20, 2013, at 2:37 p.m., review of the August 2013 physician's orders revealed Resident #2 was prescribed a low fat diet, (extra portions if desired, chopped soft foods, finely chopped meats), no concentrated sweets; nutritional supplement one can by mouth two times a day.</p> <p>On August 20, 2013, at 2:45 p.m., Resident #2's annual weight record maintained by the nursing staff was reviewed to ascertain the resident's weight history during the last twelve months, and revealed that the resident's ideal body weight was 112 to 154 pounds. Further review of the chart revealed the following body weights:</p> <p>- August 2012 through November 2012: 122 pounds</p>	I 401	<p>Cross-reference W217</p> <p>9/27/13</p>

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1401	<p>Continued From page 8</p> <p>- December 2012: 120 pounds - January 2013 and February 2013: 112 pounds</p> <p>Interview with the facility's nursing staff on August 20, 2013, at 3:32 p.m. revealed that the reason for the eight pound weight difference between December 2012 and January 2013 could not be determined.</p> <p>Note: Review of Resident #2's quarterly nutritional assessment dated February 5, 2013 on August 20, 2013, at 2:40 p.m., indicated the resident weighed 130.6 pounds (BMI - 20.5); BMI range 18.5 -24.9). The assessment recommended to continue the current nutrition regime and to reduce the nutritional supplement to two times a week, due to the resident's eight pound weight gain during the quarter. At the time of the survey, however, the source of the 130.6 pound weight could not be determined.</p> <p>March 2013 - 114 pounds April 2013 - 116 pounds May 2013 -118 pounds July 2013 - 116 pounds August 2013 - 114 pounds</p> <p>On August 20, 2013, at 2:48 p.m., review of Resident #2's annual nutritional assessment dated May, 5, 2013, revealed he was five feet, seven inches tall, weighed 116 pounds, and that his body mass index (BMI) was 18.2, placing him in the underweight range (based on his desirable body mass index of 18.5 -24.9). Further review of the nutritional assessment revealed a recommendation to continue the low fat, chopped soft food, finely chopped meats, extra portions if desired, provide nutritional supplement two times a day, and monitor weights monthly.</p>	1401	

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1401	<p>Continued From page 9</p> <p>At the time survey, there was no evidence that Resident #2's weights had been timely and accurately monitored by the nutritionist. Additionally, there was no evidence that Resident #2 received a comprehensive nutritional assessment to determine his specific caloric needs to facilitate modification in his nutrition regime, in order to effectively address his weight loss and low body weight.</p> <p>II. The GHIID failed to ensure that Resident #2 received an assessment of his recreational abilities and needs to facilitate his emotional and social enhancement, as evidenced below:</p> <p>On August 19, 2013, at 12:37 p.m., Resident #2 was observed playing with an empty water bottle and a lid when he returned to his class room at the day program after lunch. The instructor revealed that the resident did not appear to be interested in much, and frequently took walks around in the day program, which tended to calm him when he is agitated. According to the instructor, the resident was provided the opportunity to go into the community with his peers three days a week; however, his behaviors of biting and attempting to bite others, sometimes limited the type of community activities in which he was able to participate. The instructor indicated that a comprehensive recreational assessment to determine Client #2's specific wants, needs, and abilities may be beneficial to him.</p> <p>On the same day, after returning home from a walk at 4:42 p.m., Resident #2 drank a bottle of water, then stuck his finger in the bottle, began to play with it, and held onto the lid. He was then observed pulling away from his one one one</p>	1401	<p>II. The facility will request from the Recreation Specialist a comprehensive recreational assessment to determine Client #2 specific wants, needs, and abilities. The assessment will assist the day program and home to plan appropriate recreational activities and outings in the community for Client #2.</p>	9/29/13

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I 401	<p>Continued From page 10</p> <p>(Staff #2), refusing to go upstairs for hygiene care, and attempting to crawl on the floor.</p> <p>On August 20, 2013, at 1:37 p.m., interview with HM#1 indicated that Resident #2's preferred recreational choices were playing with plastic bottles, caps, and small objects, and daily walks in the community. According to HM #1, the client did not seem to enjoy most of the outings in which his peers engaged and often did not accompany them. Continued discussion with HM #1 revealed Resident #2's recreational activities were based on observation, interview with staff, and his past history, however he had not received a comprehensive assessment to identify his recreational abilities and needs.</p> <p>Review of Resident #1's individual support plan (ISP) dated June 10, 2013 through June 9, 2014, revealed the resident rarely participates with his peers and that his preferred community activity is walking. The ISP recommended, however, that the resident continue to be involved in community outings and planned activities on a regular basis for social enhancement, and that the resident be provided activities and manipulative for leisure time.</p> <p>Review of the facility's policies on August 20, 2013, at 4:25 p.m., revealed each resident shall receive a "recreation assessment annually by a recreational specialist trained and experienced in the diagnosis and habilitation of individuals with developmental disabilities. The policy further stated that the assessment shall be used to determine an individual's ability, in order to provide programs and activities that will help facilitate mental, physical, emotional and social enhancement, through purposeful participation in recreation activities.</p>	I 401		

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I 401	Continued From page 11 At the time of the survey, there was no evidence that a comprehensive evaluation by a recreation specialist had been conducted for Client #2 in accordance with his needs	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning, for one of two residents in the sample. (Resident #2) The finding includes: The facility failed to provide sufficient trained staff to ensure Resident #2 was able to attend the day program as scheduled, as evidenced below: On August 19, 2013, at approximately 9:40 a.m., Resident #1 was observed walking to the facility van. Interview with the house manager (HM #1) revealed that several of the residents had medical appointments, however, Resident #1 was going to his day program. HM #1 further stated that the	I 420	Cross-reference W186	9/6/13

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I 420	<p>Continued From page 12</p> <p>resident was scheduled to attend the day program on Monday through Friday.</p> <p>Upon arrival at the day program on August 19, 2013, at 11:55 a.m., the surveyor requested to visit Resident #1 in his treatment area. The receptionist responded that Resident #1 had not arrived yet, and that the day program had not been informed that he would not be present. Interview with the one on one (Staff #1) from the home at 12:12 p.m., revealed the resident was late arriving to his day program because two of his housemates had physician's appointments that morning.</p> <p>On August 19, 2013, at 12:08 p.m., Interview with Resident #2's day program case manager revealed the resident was always accompanied to the day program by a one on one staff provided by the home. According to the case manager, the purpose of the one on one staff was to manage the resident's targeted behaviors [biting, attempted biting, eating of non-eatable objects (pica)], and to assist with his active treatment. Upon checking the record, on August 19, 2013, at 12:05 p.m., the case manager stated the resident attended the day program four days in July 2013 and about the same number of days in June 2013. The case manager revealed that the resident had been absent from the day program due to his helmet being broken, and the lack of an assigned one on one staff to supervise him while at the day program.</p> <p>During Interview with the house manager (HM #1) on August 20, 2013, at 2:00 p.m., It was confirmed that Resident #2 had attended his day program infrequently during June and July 2013 due to his helmet being broken, and also because his assigned relief one to one staff (8:00 a.m. -</p>	I 420		

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I 420	<p>Continued From page 13</p> <p>4:00 p.m. shift) had resigned in June 2013. HM #1 stated that the resident received a new helmet on July 30, 2013, and now goes to the day program every week day, except when his full time one on one staff is scheduled off duty. According to HM #1, Staff #1 is scheduled off on Thursday and Friday (every other week), prior to his weekend to work. HM #1 revealed that the resident remains home on those Thursdays and Fridays because the agency had not been successful in recruiting a part-time one on one staff to replace the staff who resigned from the shift (8:00 a.m.- 4:00 p.m.) in June 2013.</p> <p>On August 20, 2013, at 2:17 p.m., review of records at the home confirmed that the resident did not attend his day program seven (7) days in June 2013 and eleven (11) days in July 2013. Further discussion with HM#1 revealed that on Staff #1's days off, Resident #2 was monitored by various direct support staff who had been trained on Resident #1's behavior support plan, but had not been oriented to supervise the resident at his day program. Further inquiry regarding the resident's alternative schedule when he did not attend his day program revealed it had not been developed yet.</p> <p>On August 20, 2013, at 3:30 p.m., review of proactive strategies identified in Resident #2's behavior support plan (BSP dated May 8, 2013, revealed the facility should "maintain a consistent routine and staffing (1:1/24:7), and set limits and expectations." Further record review revealed staff were trained on Resident #2's BSP on July 9, 2013 and July 10, 2013, by qualified intellectual disabilities professional (QIDP).</p> <p>At the time of the survey, however, the facility failed to ensure that sufficient trained staff was</p>	I 420	

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I 420	Continued From page 14 available to manage and supervise Resident #1 in accordance with his individual program plan.	I 420		
I 474	<p>3522.5 MEDICATIONS</p> <p>Each GHMRP shall maintain an individual medication administration record for each resident.</p> <p>This Statute Is not met as evidenced by: Based on observation, interview and record review the group home for individuals with intellectual disabilities (GHID) nursing staff failed to maintain the medication administration record (MAR) for one of four residents receiving medications. (Resident #1)</p> <p>The findings include:</p> <p>1. Observation of the medication administration on August 19, 2013, beginning at 8:20 a.m., revealed Resident #1 was observed to receive Aspirin, Calcium, Tegretol, Colace, Fluoxetine, Keppra, Risperdal, Systane and Dorzolamide eye drops from the morning licensed practical nurse (LPN #1).</p> <p>Review of Resident #1's medication administration records (MAR) on August 19, 2013, beginning at 10:30 a.m., revealed the following:</p> <ul style="list-style-type: none"> - July 2013 MAR revealed there were no initials documented that indicated the resident was administered Systane eye drops on July 12, 2013; - April 2013 MAR revealed there were no initials documented that indicated the resident was 	I 474	Cross-reference W365 (1)	9/27/13

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I 474	<p>Continued From page 15</p> <p>administered Risperdal, Simvastin, Docusate, Prozac, Keppra, Aspirin, Calcium, Tegretol, Travaton eye drops, Dorzolamide eye drops and Oxistat skin cream on April 27, 2013;</p> <p>- January 2013, MAR revealed there were no initials documented that indicated the resident was administered Keppra, Calcium, Tegretol, Docusate, Travaton and Dorzolamide eye drops on January 12, 2013. Further review revealed there were no initials for Risperdal, Aspirin, Calcium, Tegretol, Docusate, Fluoxetine, Systane and Dorzolamide eye drops on January 21, 2013. There were also no initials documented that indicated the resident was administered Calcium on January 13, 2013;</p> <p>- December 2012, MAR revealed there were no initials documented that indicated the resident was administered Risperdal, Docusate, Fluoxetine, Keppra, Aspirin, Calcium, Tegretol, Oxistat skin cream, Systane and Dorzolamide eye drops on December 22, 28, 29 and 30, 2012;</p> <p>- November 2012, MAR revealed there were no initials documented that indicated the resident was administered Risperdal, Simvastin, Keppra, Calcium, Tegretol, Travaton, Systane and Dorzolamide eye drops on November 24 and 25, 2012. There were also no initials documented that indicated the resident was administered Docusate, Fluoxetine and Aspirin on November 25, 2012.</p> <p>Continued review of the MARs for January 2013, May, October and November 2012 on February 7, 2013, revealed that there was no information documented on the back of the MARs to explain why the initials were missing.</p>	I 474	

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I 474	<p>Continued From page 16</p> <p>Interview with the registered nurse (RN #1) on August 20, 2013, at 4:51 p.m., revealed that the MAR's required an initial when medication is administered and a written explanation on the back of the MAR's when medication is not given. Further interview revealed Resident #1's medications was sent home with the resident on the aforementioned dates.</p> <p>2. Observation of the medication administration on August 19, 2013, at 12:17 p.m., at the day program revealed Resident #1 was observed to receive Tegretol from the day program licensed practical nurse (LPN #2).</p> <p>Review of Resident #1's MAR and his physician's order sheets on August 20, 2013, at 4:51 p.m., revealed the resident was prescribed Tegretol three times a day. However, there was no MAR's that revealed the 12:00 p.m. administration.</p> <p>On August 20, 2013, at 2:45 p.m., interview with RN #1 confirmed that the resident receives Tegretol at the day program and that the day program had not been sending the MARs back to the facility. The RN further stated that the facility was required to maintain all MARs, therefore the day program should have been sending the MARs back to the facility.</p> <p>At the time of the survey, the facility failed to maintain all MARs for Resident #1.</p>	I 474	Cross-reference W365 (2)	9/27/13
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