

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

PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2012
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

A recertification survey was conducted from June 13, 2012 through June 15, 2012. A sample of three clients was selected from a population of six men 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 one day program, interviews with clients, 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 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to assure that the day treatment program implemented all recommended active treatment programs (i.e. language development training), for one of three clients in the sample. (Client #1)

The finding includes:

Client #1 was observed at his day program on June 14, 2012, beginning at 11:30 a.m. At approximately 12:20 p.m., the day program activities coordinator (DPAC) stated that the

W 000

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

W 120

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mamber Tinsan</i>	TITLE <i>DY/O.S.H.C</i>	(X6) DATE <i>6/29/12</i>
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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 Continued From page 1

client's annual Individual Support Plan (ISP) meeting was held on May 9, 2012. According to the DPA/2, the interdisciplinary team recommended a language enrichment/ communication training program. The DPAC further stated that it had not yet been implemented because photographs had not yet been taken of Client #1 engaged in various activities around the day program setting. The photographs were to be the key component of a "communication board" necessary for program implementation.

On June 14, 2012, at 2:01 p.m., interview with the qualified intellectual disabilities professional in the home confirmed that Client #1's ISP included a new communication training program involving the use of pictures. He stated that the program was already implemented in the home, presented performance data recorded by residential staff starting on May 12, 2012, and confirmed that a comparable program was to be implemented at the client's day program.

The facility failed to ensure that Client #1's day program implemented the client's language enrichment training program, in accordance with his annual plan.

W 252 483.440(e)(1) PROGRAM DOCUMENTATION

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by:

W 120 The day program activities coordinator (DPAC) was trained by the Q.I.D.P on 06-18-12 on the speech & language program. This is currently being implemented at the group home for Client #1. Data collection sheet was also developed for the day program. The Q.I.D.P will monitor the implementation of the speech program for Client #1 on a monthly basis at the day program. The Q.I.D.P will also ensure all recommended IPP goals for all individuals are implemented at various day programs in a timely manner, through monthly visits to the clients day programs. (See Attachment "1A" & "1B")

06-18-12

W 252

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W 252 Continued From page 2

W 252

Based on observation, interview and record review, the facility's medication nurses failed to accurately document performance data in accordance with self-medication training programs, for one of the three clients in the sample. (Client #1)

The finding includes:

The morning medication administration was observed on June 14, 2012. At 7:57 a.m., the medication nurse placed Client #1's medications and nutritional supplements (Hydroxyzine HCL, Multi-Vitamin, Calcium and Vitamin D3) into a 4oz cup of apple sauce and spoon fed him the mixture. At 7:59 a.m., the nurse asked him to hold a cup of water. The client refused to take the cup, turned his head and shouted "no" in a loud voice. The nurse repeated her request a second time and the client again refused to take the cup. Eventually, the client took a small sip of water from the cup she held, stood up and quickly left the room. The nurse then discarded the cup.

On June 14, 2012, at 9:37 a.m., review of Client #1's medication administration records (MARs) revealed a data collection sheet on which medication nurses had been documenting the client's performance with a self-medication training program. Steps 3, 4 and 5 of the task analysis were as follows: "pick up cup of water, drink water, and put cup in trash." Continued review of the data collection sheet revealed that the nurse had written an "I" to record the client's performance with each of the last 3 tasks for that morning. The key on the data sheet indicated "I" stood for "independent." The data, however, differed from what was observed during the

After learning about the identified issues (on 06/15/12 around 11am only) D.O.N/D.C.H.C contacted the nurse who administered the AM medications on 06/14/12. Immediate training on the 5 steps to ensure proper and accurate medication administration to follow all the rules and the self med steps given to nurses on 06/15/12 by DON. Due to a medication error observed and identified the nurse has been suspended for one week. The nurse needs to do a refresher course on medication administration before returning to work. If the nurse does return to work, D.O.N will monitor her med pass for one week every day then unannounced weekly, and 1x per

06-15-12

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W 252 Continued From page 3
medication administration observations earlier that day.

On June 15, 2012, at approximately 9:30 a.m., interview with the qualified intellectual disabilities professional revealed that the self-medication training program was a formal component of Client #1's Individual Support Plan, dated May 9, 2012 (this was verified at the same time).

The facility failed to ensure that the morning medication nurse accurately documented Client #1's skills/performance during the medication administration that was observed on June 14, 2012.

W 252 month to ensure that no error of this kind is ever repeated.
The Q.I.D.P will ensure that all self medication programs are implemented and documented as completed and observed. The Q.I.D.P will monitor and review data sheets monthly to ensure that documentation is accurate and consistent. This is also ensured during monthly round table meetings.
(Attachments #2a,2b,2c)

W 369 483.460(i)(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 two of the six clients residing in the facility. (Clients #4 and #6)

The findings include:

The morning medication administration was observed on June 14, 2012, from 7:00 a.m. until 8:17 a.m. Two administration errors were subsequently identified, as follows:

1. At approximately 8:05 a.m., Client #4 received his medications and supplements (Metharine Hippur, Senna, Multi-Vitamin, and Calcium with

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W 369: Continued From page 4
Vitamin (J)). At 9:45 a.m., review of his medication administration record (MAR) and his physician's order sheets (POS) for June 2012 revealed that he was prescribed "Plavix U-D 75 mg tablet, 1 tab by mouth every day for prophylaxis." The designated time on the MAR was 7 a.m. He had not been observed receiving Plavix during the morning medication administration. [Note: Continued review of Client #4's MAR revealed the morning medication nurse (N1) had initialed the MAR, indicating the Plavix was given.]

W 369
1&2 Please see Answer to W-252. 06-15-12

A registered nurse (RN1) came to the facility on the morning of June 15, 2012. When RN1 was interviewed, beginning at 9:28 a.m., she looked through the medicine closet and stated that she could not locate a blister pack for Client #4's Plavix. She examined his MAR and confirmed that N1 had initialed it on the mornings of June 14 and June 15, 2012, as if the Plavix had been administered. She further stated that she was previously unaware of any medications that needed refilling.

2. On June 14, 2012, at approximately 8:14 a.m., Client #6 received his medications and supplements (Quelapin Fum, Olanzapine, Calcium, Multi-Vitamin, Senna, Phenytoin and Haldol 2mg). At 9:27 a.m., the qualified intellectual disabilities professional (QIDP) stated that Client #6's medical records, including his POS, were at the primary care physician's (PCP's) office. At 10:22 a.m., review of his June 2012 MAR revealed no space identified for documenting the administration of Haldol and there was no written evidence or documentation in the MAR showing that Client #6 was administered Haldol 2 mg that morning. At 4:13

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W 369

p.m., review of the typed POS prepared by the pharmacy failed to show evidence of an order for Haldol.

On June 15, 2012, at 9:39 a.m., RN1 stated that Client #6 had been prescribed Haldol for a one-time administration. She presented Client #6's MAR and showed where she had added a line for documenting Haldol 2 mg. She then confirmed that she had just finished adding it to the MAR that morning. She presented a handwritten physician's order, dated June 13, 2012, that outlined preparations needed, including administration of Haldol 2 mg for a colonoscopy that was scheduled for June 18, 2012. When informed that the client was observed being administered Haldol 2mg on the morning of June 14, 2012, RN1 retrieved the blister pack from the medicine closet and upon examination, confirmed that the one tablet of Haldol originally packaged by the pharmacy for June 18, 2012 was no longer in its bubble. RN1 stated that she was previously unaware of any medication errors from the day before and left the facility shortly thereafter.

During the Exit conference held on June 15, 2012, beginning at 6:15 p.m., the Director of Nursing (DON) reported that N1 had confirmed that she had administered 2 mg of Haldol to Client #6 on the morning of June 14, 2012. N1 also had admitted to the DON that she did not compare each blister pack with each client's MAR at the time she was preparing the medications, in accordance with the facility's policies. According to the DON, the physician arranged for the client to receive another dose of Haldol (for June 18, 2012) and the facility had a

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previously-established agreement with a local pharmacy to ensure same-day delivery if/when a prescription needed filling. She went on to acknowledge, however, that the medication nurses failed to implement the system (i.e. failed to reconcile medications with MAR's and/or to notify an RN that a medication was needed) to ensure that Clients #4 and #6 received all prescribed medications without error.

W 369

It should be noted that observations of Client #6 in the facility on June 14, 2012, at 4:50 p.m. revealed no indication of lethargy or adverse reaction. On June 15, 2012, at 3:16 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the client's primary care physician (PCP) had been notified of the medication errors that morning (confirmed by the PCP through telephone interview at 3:35 p.m.). The QIDP further stated that an unusual incident report had been generated and an investigation would follow. Telephone interview with the case manager at Client #6's day program, followed by a face to face interview with the house manager, at 4:14 p.m. and 4:55 p.m. respectively, revealed that neither they nor their staff had observed anything different or unusual with Client #6 on the day before.

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1 000 INITIAL COMMENTS

1 000

A licensure survey was conducted from June 13, 2012 through June 15, 2012. A sample of three residents was selected from a population of six men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at one day program, interviews with residents, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

1 422 3521.3 HABILITATION AND TRAINING

1 422

Each QMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.

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 all staff, including those employed by the residents' day programs, implemented training programs in accordance with residents' Individual Support Plans (ISPs), for one of the three residents in the sample. (Resident #1)

The findings include:

1. The facility failed to ensure that Resident #1's day program implemented the resident's language enrichment training program timely and in accordance with his annual plan, as follows:

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
M. Montaloni, M.S., R.N.

TITLE
DY/D.C.H.C.

(X6) DATE
6/29/12

STATE FORM

8000 LV0Y11

If continuation sheet 1 of 6

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I 422	<p>Continued From page 1</p> <p>Resident #1 was observed at his day program on June 14, 2012, beginning at 11:30 a.m. At approximately 12:20 p.m., the day program activities coordinator (DPAC) stated that the resident's annual Individual Support Plan (ISP) meeting was held on May 9, 2012. According to the DPAC, the interdisciplinary team recommended a language enrichment/communication training program. The DPAC further stated that it had not yet been implemented because photographs had not yet been taken of Resident #1 engaged in various activities around the day program setting. The photographs were to be the key component of a "communication board" necessary for program implementation.</p> <p>On June 14, 2012, at 2:01 p.m., interview with the qualified intellectual disabilities professional in the home confirmed that Resident #1's ISP included a new communication training program involving the use of pictures. He stated that the program was already implemented in the home, presented performance data recorded by residential staff starting on May 12, 2012, and confirmed that a comparable program was to be implemented at the resident's day program.</p> <p>2. The facility failed to ensure that medication nurses accurately recorded Resident #1's performance/ participation during implementation of a self-medication training program, as follows:</p> <p>The morning medication administration was observed on June 14, 2012. At 7:57 a.m., the medication nurse placed Resident #1's medication and nutritional supplements (Hydroxyzine HCL, Multi-Vitamin, Calcium and Vitamin D3) into a 4oz cup of apple sauce and</p>	I 422 1.	<p>The day program activities coordinator (DPAC) was trained by the Q.I.D.P on 06-18-12 on the speech & language program currently being implemented at the group home for Client #1. Data collection sheet was also developed for the Day Program.</p> <p>The Q.I.D.P will monitor the implementation of the speech program for Client #1 on a monthly basis at the day program. The Q.I.D.P will also ensure all recommended IPP goals for all individuals are implemented at various day programs in a timely manner through monthly visits to Client's day program.</p> <p>(See Attachment "1A" & "1B")</p>
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spoon fed him the mixture. At 7:59 a.m., the nurse asked him to hold a cup of water. The resident refused to take the cup, turned his head and shouted "no" in a loud voice. The nurse repeated her request a second time and the resident again refused to take the cup. Eventually, the resident took a small sip of water from the cup she held, stood up and quickly left the room. The nurse then discarded the cup.

On June 14, 2012, at 9:37 a.m., review of Resident #1's medication administration records revealed a data collection sheet on which medication nurses had been documenting the resident's performance with a self-medication training program. Steps 3, 4 and 5 of the task analysis were as follows: "pick up cup of water, drink water, and put cup in trash." Continued review of the data collection sheet revealed that the medication nurse had written an "I" to record the resident's performance with each of the last 3 tasks. The key on the data sheet indicated "I" stood for "Independent." The data, however, differed from what was observed during the medication administration observations earlier that day.

On June 15, 2012, at approximately 9:30 a.m., interview with the QIDP revealed that the self-medication training program was a formal component of Resident #1's ISP, dated May 9, 2012 (this was verified at the same time).

1 422

2. After learning about the identified issues (on 06/15/12 around 11am only) D.O.N/D.C.H.C contacted the nurse who administered the AM medications on 06/14/12. Immediate training on the 5 steps to ensure proper and accurate medication administration to follow all the rules and the self med steps given to nurses on 06/15/12 by DON. Due to a medication error observed and identified, the nurse has been suspended for one week. The nurse needs to do a refresher course on medication administration before returning to work. If the nurse does return to work, D.O.N will monitor her med pass for one week every day then unannounced weekly, and 1x per month to ensure that no error of this kind is ever repeated. The Q.I.D.P will ensure that all self medication programs are implemented and documented as completed and observed.

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1 474 3522.5 MEDICATIONS

Each GHMRP shall maintain an individual medication administration record for each resident.

This Statute is not met as evidenced by:

1 474

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been administered Haldol 2 mg that morning.

1474

On June 15, 2012, at 9:30 a.m., a registered nurse (RN1) looked through the medicine closet and stated that she could not locate a blister pack for Resident #4's Plavix. She examined his MAR and confirmed that N1 had initialed it on the mornings of June 14 and June 15, 2012, as if the Plavix had been administered. At 9:39 a.m., RN1 stated that Resident #6 had been prescribed Haldol for a one-time administration. She presented Resident #6's MAR and showed where she had added a line for documenting Haldol 2 mg. She then confirmed that she had just finished adding it to the MAR that morning. She presented a handwritten physician's order, dated June 13, 2012, that outlined preparations needed, including administration of Haldol 2 mg to a colonoscopy that was scheduled for June 18, 2012. When informed that the resident was observed being administered Haldol 2mg on the morning of June 14, 2012, RN1 retrieved the blister pack from the medicine closet and upon examination, confirmed that the one tablet of Haldol originally packaged by the pharmacy for June 18, 2012 was no longer in its bubble.

1500 3523.1 RESIDENT'S RIGHTS

1500

Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.

This Statute is not met as evidenced by:
Based on observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER (OR SUPPLIER) D C HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 500	Continued From page 5 and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the six residents of the GHPID. (Resident #6) The finding includes: Chapter 13, § 7-1305.05. Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly § 6-1965] (h) All customers have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written or verbal order of a licensed physician, noted promptly in the patient's medical record and signed by the physician within 24-hours. The GHPID failed to ensure that Resident #6 received psychotropic medication only on the date specified by the prescribing physician, as follows: On June 14, 2012, at approximately 8:14 a.m., Resident #6 was observed being administered Haldol 2mg. At 10:22 a.m., review of the resident's June 2012 medication administration record (MAR) revealed no space identified for documenting the administration of Haldol and there was no written evidence or documentation in the MAR showing that Resident #6 was administered Haldol 2 mg that morning. On June 14, 2012, at 9:39 a.m., a registered nurse (RN) stated that Resident #6 had been prescribed Haldol for a one-time administration.	I 500			
		1& 2	Please see Answer I 422#2	06-15-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2012
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019	

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RN1 immediately presented a handwritten physician's order, dated June 13, 2012, that outlined preparations needed, including administration of Haldol 2 mg to a colonoscopy that was scheduled for June 18, 2012. When informed that the resident was observed being administered Haldol 2mg on the morning of June 14, 2012 RN1 retrieved the blister pack from the medicine closet and upon examination, confirmed that the one tablet of Haldol originally packaged by the pharmacy for June 18, 2012 was no longer in its bubble.

During the Exit conference held on June 15, 2012, beginning at 6:15 p.m., the Director of Nursing (DON) reported that N1 had confirmed that she had administered 2 mg of Haldol to Resident #6 on the morning of June 14, 2012. The DON further stated that the physician had arranged for the resident to receive another dose of Haldol to be administered on June 18, 2012.

It should be noted that observations of Resident #6 in the facility on June 14, 2012, at 4:50 p.m. revealed no indication of lethargy or adverse reaction. (On June 15, 2012, at 3:18 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the resident's primary care physician (PCP) had been notified of the medication errors that morning (confirmed by the PCP through telephone interview at 3:35 p.m.). The QIDP further stated that an unusual incident report had been generated and an investigation would follow. Telephone interview with the case manager at Resident #6's day program, followed by a face to face interview with the house manager, at 4:14 p.m. and 4:55 p.m. respectively, revealed that neither they nor their staff had observed anything different or unusual with Resident #6 on the day before.

