

Received 12/6/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  CRF-000958	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  11/06/2013
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NAME OF PROVIDER OR SUPPLIER: SEABURY RESOURCES FOR AGING  
STREET ADDRESS, CITY, STATE, ZIP CODE: 2501 18TH STREET NE WASHINGTON, DC 20018

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D 000	<p><b>Initial Comments</b></p> <p>An initial licensure survey was conducted on November 5, 2013, through November 6, 2013. A sample of four residents was selected from a population of five males and two females with varying degrees of medical disabilities.</p> <p>The findings of the survey were based on observations in the home, interviews, as well as a review of client and administrative records, including incident reports.</p> <p>Note: Below are abbreviations that may appear throughout the body of this report:</p> <p>Community Residence Facility - CRF Resident Care Coordinator - RCC Primary Care Physician - PCP Medication Administration Record - MAR Milligram - MCG Home First Nurse - HFN Trained Medication Employees - TME Milligram - MG Microgram - MCG Residential Director - RD</p>	D 000	<p><b>Overview-</b> On November 5, the DOH surveyor provided the Resident Director (RD) a copy of Title 22, chp.61. Since the receipt of the regulation, the Community Residential Facility (CRF) corrected the medication storage deficiency through the following actions: A.)The CRF has a Medication Management Team consisting of registered nurse (RN), Licensed Practical Nurse (LPN), and Trained Medication Employees (TMEs)/Caregiver. B.) Currently, all medications are administered by registered nurses. C.)The CRF is in the process of hiring a licensed practical nurse (LPN) to serve as a back-up and also work periodically during the day to address medical needs. It is projected that LPN staff will be in place by December 30, 2013. D.) The CRF is actively pursuing the hiring of TMEs as part of its MMT team. Since the inspection, the current Caregiving staff has participated in Trained Medication Employee training (paid by CRF), and are waiting for the test dates from the DC Board of Nursing (BON). E.) Effective January 1, 2014, CRF requires that the Caregiving staff must be certified TME or in the process of obtaining TME licensure. F) The medication administration policy has been revised and updated. See all supporting documents.</p> <p><b>In regards of quality assurance (QA):</b> A.) On Dec. 20, 2013, the RD will hold a QA meeting with MMT team, to address agency changes. B.) RD will hold QA meetings to ensure compliance will be held on a bi-monthly basis. C.) The direct care staff is projected to be licensed as TMEs by 1/30/14. D.) The CRF nurses will conduct a series of in-service trainings for the Caregiving/TME staff which will include but not limited to: Medication policy; Incident reporting; Emergency procedures; Clinical procedures and protocols. The in-services will be documented via staff sign in sheet, Topic, and training syllabus and completed by 2/15/14. CRF nurses will continue to provide in-service trainings and monitor medication administration on an ongoing basis. E.) Residence competency to administer medications assessment will be conducted annually at a minimum and more often as indicated. The Self-Administration Checklist Assessment tool will be used to determine competency levels for each resident at least once a year. The next assessment of CRF residents will be conducted by CRF nurses no later than 12/30/13. An assessment tool will be created by the RN for the TMEs to assess residents' ability to self administer medications as prescribed on a quarterly basis. See Document. F.) Pursuant to chp.61, the licensed nurse will monitor TMEs on a monthly basis, and quarterly review of the medication policy on a quarterly basis. G.) Notification of Medication Administration policy: CRF will notify residents and representatives of the revised medication administration within ten (10)days of approval of this Corrective Action Plan (CAP). It is anticipated that this action will be completed no later than January 10, 2014.</p>	
D 170	<p><b>3400.2(b) General Provisions</b></p> <p>(b) The implementation of policies, practices, and procedures of the community residence facility, including the screening of prospective residents;</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the CRF failed to ensure that the medication management policy addressed the disposal of medications for all the residents residing in the facility. (Residents #1, #2, #3, #4, #5, #6, and #7). Additionally, the CRF failed to ensure that the medication policy related to</p>	D 170		

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

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D 170	<p>Continued From page 1</p> <p>medication error was implemented for one of seven residents residing in the facility. (Resident #6)</p> <p>The finding includes:</p> <p>Observation of the medication pass on November 6, 2013, beginning at 7:24 a.m. revealed that Resident #6 received Omeprazole 20 mg, Docusate 100 mg, and Aspirin. At 7:53 a.m., Resident #7 was observed to enter the sitting area where the medication was being administered. Resident #7 was overheard telling the nurse that there was a pill on the floor. The nurse revealed that he/she was aware that the pill was on the floor. Interview with the nurse immediately after acknowledging that the medication was on the floor, revealed that the medication was not Resident #7's pill, but that it was Resident #6's Omeprazole. Further interview with the nurse, revealed that he/she planned to throw the pill in the trash, and that if it had been a lot of pills she/he would have disposed of the medications in coffee grinds.</p> <p>Review of the medication management policy on November 4, 2013, during the pre-surveying process, revealed that all medication errors be documented as an unusual incident. Interview with the RCC on November 6, 2013, revealed that the nurse had not completed an incident report regarding Resident #6's Omeprazole that was dropped on the floor during the medication pass.</p> <p>Additionally, review of the medication management policy addressed how narcotics and discontinued medications should be discarded, however, the policy failed to address how other medications (i.e., Omeprazole) were to be</p>	D 170	<p><u>Systemic Changes</u></p> <p>Page1 D170- 3400.2 As part of the <u>systemic changes</u> to ensure that the deficient practice will not reoccur; the CRF has revised the medication policy and also made significant changes in personnel and operations. The policy addresses the disposal of wasted medications, and medication omissions. The licensed registered nurse will oversee day to day aspects of medical care: monitor medication administration, MAR, nursing coordination, and provide general supervision and in-service trainings to LPN and direct staff, and ensure compliance with Title 22: 3400 and 6100 regulations.</p> <p>Explained by nurse, Resident #6 did receive medication. An unusual report was written for the wasted medication omission. In the revised medication policy, all wasted medications will be dispensed in the coffee grind canister and noted on the Medication Disposal Form by the registered nurse.</p>	<p>12/2/13</p> <p>11/20/13</p>

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D 200	<p>3400.2(e) General Provisions</p> <p>(e) The supervision of the community residence facility's sanitation, safety, laundry, and dietary standards and services, and of its services relating to the health, education, and welfare of its residents;</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the RD failed to ensure the resident's received their medications timely and accurately and failed to ensure medical devices were maintained and in good working condition.</p> <p>The findings include:</p> <p>1. On November 6, 2013, at 7:24 a.m. Resident #6 was observed being administered his/her morning medications as follows: Omeprazole 20 mg, Docusate 100 mg, and Aspirin. During the medication administration reconciliation, the physician's orders were reviewed and revealed that Resident #6 was ordered Spiriva HaniHaler, 18 mcg, one inhalation daily at 8:00 a.m. was not observed being administered.</p> <p>Continued review of the MAR revealed that the facility's nurse had not initialed the MAR, or documented on the back of the MAR why the resident was not provided with the inhaler. On November 6, 2013, at 5:59 p.m., interview with the RCC verified that the nurse had not written an explanation on the back of the MAR as to why the inhaler was not provided. Upon completion of the administration of medications, the facility's nurse was not available for interview, nor was their any</p>	D 200	<p>Page 2 D170 - On November Resident #6 Omperazole was given to resident. As stipulated in the revised policy, the licensed nurse did discard the pill in the trash and also wrote an Incident report on the medication omission. Report was submitted to DOH on 11/26/13. See Document</p> <p>1. Explained by the nurse, the resident did receive the Spiriva inhaler 18mcg. Resident was given the Spriva Hani-Haler 18mcg along with other meds. Nurse gave to resident inhaler, who self administered the medication.</p>	<p>11/26/2013</p> <p>11/6/2013</p>

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D 200	<p>Continued From page 3</p> <p>licensed personnel to verify if the Spiriva HandHaler was available for administration. It should be noted that the MAR for the previous days indicated that the medication was available and administered.</p> <p>2. Additionally, Resident #6 was observed to receive Omeprazole 20 mg, Docusate 100 mg, and Aspirin 81 mg. The resident was observed to swallow all of the aforementioned pills and the nurse verified that Resident #6 swallowed them. Review of the physician's order on November 6, 2013, at 9:00 a.m. revealed that the Aspirin was prescribed to be chewed instead of swallowed.</p> <p>3. Resident #2 was observed to receive Alendronate 70 mg. Review of the MAR on November 6, 2013, at 9:30 a.m. revealed that the Alendronate was prescribed to be given before eating or drinking anything. The resident was also observed to receive Levothyroxin, one tab daily, on an empty stomach. Observation on the same morning revealed that Resident #2 had eaten his/her breakfast beginning at 6:50 a.m.</p> <p>4. During the medication pass at 7:41 a.m., Resident #2 was observed to receive Latanoprost 0.005 % solution in both eyes. Review of the MAR revealed that the eye drops were prescribed to instill one drop in each eye at bedtime. The nurse was questioned about administering the evening eye drops during the morning medication pass. After examining the label, she appeared surprized and stated, "he gets that in the evening?"</p> <p>5. Observation on November 5, 2013, at 4:05 p.m. revealed Resident #6 had arrived home from his/her day treatment program. The resident was observed standing in his/her bedroom, where an</p>	D 200	<p>2. The registered nurse will ensure that the residents will follow the prescribed orders with medication administration.</p> <p>3. The caregiving staff should not have allowed resident #2 to eat prior to medication administration. Morning staff has been instructed that Resident #2 should not have breakfast until the nurse administers medication at 6:30 am.</p> <p>4. The registered nurse will ensure that the residents will follow the prescribed orders with medication administration.</p> <p>5. Resident #6- The House Call PCP sent an order stating the resident prefers to administer the medication at night. See document.</p>	<p>Daily</p> <p>11/7/13</p> <p>11/20/13</p>

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D 200	<p>Continued From page 4</p> <p>oxygen canister was observed sitting in the corner. Interview with the resident revealed that he/she uses oxygen at night before retiring for the evening.</p> <p>Interview with the RCC on November 6, 2013, at 11:15 a.m. verified that Resident #6 used his/her oxygen at night and independently places the nasal canula in his/her nose before going to bed. Additionally, the resident sleeps with the canula throughout the night and removes it the next morning.</p> <p>Record review on November 6, 2013, at 11:45 a.m. revealed a physician's order dated December 18, 2012. Review of the order revealed that the resident was to "use home oxygen 24 hours a day, oxygen saturation is low when [resident's name] is not on [his/her oxygen]." Further interview with the RCC, revealed that Resident #6 never used or had a portable oxygen tank available. It should be noted that the resident's PCP made a home visit on the same day (December 18, 2012). Continued review of the resident's record revealed that the PCP's assessment noted that the resident used oxygen for twenty-four hours a day.</p> <p>Continued interview and review of the resident's record did not evidence a physician's order to discontinue the 24 hour order for Resident #6 to receive oxygen. It should be noted that the resident's record on November 6, 2013, at 12:45 p.m. revealed that the resident had another home visit with his PCP on May 8, 2013. The doctor's note indicated to continue oxygen at night, however, there was not an order to discontinue the 24 hours.</p>	D 200	<p>5. Continued</p> <p>The House Call NP sent an order for portable machine. See Document.</p>	12/3/13

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D 200	<p>Continued From page 5</p> <p>6. Record review on November 6, 2013, at 1:25 p.m. revealed that the facility was provided with a document entitled "Oxygen Concentrator Training." Review of the document revealed a section entitled "Care and Maintenance." Further review of the Care and Maintenance of the oxygen concentrator revealed that the gray filters on each side should be removed once a week. The filters should be washed in warm water and non-lotion detergent. The filters also should be rinsed with warm water, and gently squeeze excess water from the filter and pat dry with towel.</p> <p>Interview with the RCC on November 8, 2013, at approximately 2:00 p.m. revealed that there was no care/maintenance of Resident #6's oxygen concentrator.</p>	D 200	The CRF has created a Check-off Care and Maintenance List to ensure the oxygen concentrator is cleaned weekly. See Document.	12/3/13