

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2013
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 806 FLORAL PL, NW WASHINGTON, DC 20012
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I 000	INITIAL COMMENTS A licensure survey was conducted on July 11, 2013 through July 12, 2013. A random sample of three residents was selected from a resident population of two females and three females with varying degrees of intellectual disabilities. The survey findings was based on observations in the home, interviews with administrative management, nursing and direct care staff, and the review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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. 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 residents who was prescribed psychotropic medication had a psychiatric evaluation to evidence an Axis I diagnoses for one of the two residents included in the sample (Resident #1). The findings include: Interview with the facility's house manager (HM) on July 11, 2013, at 10:25 a.m. revealed	I 401		

Received 8/3/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Michael [Signature] Program Director

TITLE

(X6) DATE

8-26-2013

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I 401	<p>Continued From page 1</p> <p>Resident #1 was prescribed psychotropic medications to include Amoxapine 100 milligrams (mg) twice a day, and Seroquel 500 mg a day, and had a behavior support plan (BSP) to manage her maladaptive behaviors.</p> <p>Review of records on July 11, 2013, at 11:01 a.m., revealed Resident #1 had a behavior support plan (BSP) dated February 15, 2013. The plan documented three behavioral goals to include reducing incidents of disruption (excessive cleaning, stuffing the commode with paper towels, abruptly getting up to engage in activities at inappropriate times (i.e. going to the bank at night), invading others personal space, and making inappropriate requests (for food or money). Further review of the BSP revealed Resident #1 had an Axis I diagnosis of intermittent explosive disorder and psychotic disorder.</p> <p>Interview with the qualified intellectual disability professional (QIDP) and review of the resident's medical record on July 11, 2013, at 2:04 p.m. revealed her psychotropic medications were reviewed on a monthly basis. On July 11, 2013, at 2:04 p.m. the resident's record revealed a psychotropic medication review dated June 4, 2013. The medication review revealed Resident #1's Axis I's diagnosis was obsessive compulsive disorder, which was different from the axis I diagnosis included in her BSP. According to the QIDP, and review of the resident's medical record on July 11, 2013, at 2:06 p.m. revealed no documented evidence of a psychiatric evaluation to verify the resident's Axis 1 diagnosis.</p> <p>At the time of the survey, the GHIID failed to ensure Resident #1 had a psychiatric evaluation that included the resident's diagnosis,</p>	I 401	<p><i>Upon review of Individual's Psychiatric Medication review dated 7-27-2013 and BSP dated 2-15-2013 the axis I diagnosis was not consistent. Please find attached email to the BSP developer Dr. Yount to correct the axis I diagnosis to be consistent with the Psychiatrist. Additionally the HRC will document that the axis I diagnoses are consistent before approval is given.</i></p>	8-26-13

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I 401	Continued From page 2 developmental levels and needs, treatment services that designed to prevent deterioration or further loss of function by the resident.	I 401		
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 interview and record review, the group home for persons with intellectual disabilities (GHID's) nursing staff failed to ensure each residents' medication administration records (MAR) were maintained for one of two residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Review of Resident #2's medical record on July 12, 2013, beginning at 11:01 a.m., revealed physician orders dated September 11, 2012. The order prescribed Eskalith (Lithium) 450 mg, one tab every morning and Ativan 1 mg, every evening, q pm. Further review of the record revealed additional physician's orders dated September 18, 2012. The order prescribed Advair Diskus, one puff twice daily, and Advair Diskus one puff twice daily for one month. Review of Resident #2's medication administration records (MAR) failed to evidence a MAR for the month of September 2012.</p> <p>Interview with the facility's licensed practical nurse (LPN) on July 12, 2013, at 4:30 p.m. verified that there was no documented evidence of a September 2012, MAR for Resident #2.</p>	I 474	<p>Upon review of Individual's #2 medical record, specifically MAR's the MAR for September 2012 was missing. LPN's are required to insert all completed MAR's into the Individual's medical record. The LPN assigned to this facility at the time of the missing MAR no longer works with us. Further the assigned RN is required to review all completed MAR's and sign off that they there were no errors. Again</p>	

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I 474	Continued From page 3 At the time of the survey, the GHIID failed to maintain a MAR for the month of September 2012, and to provide documented evidence if Resident #2 was administered Eskalith (Lithium) 450 mg, Ativan 1 mg, and the Advair Diskus.	I 474	<i>The RN that was assigned to this facility at the time of the missing MAR no longer works with us.</i>	8-26-13
I 479	3522.6(e) MEDICATIONS The record for a resident's prescribed controlled substances shall include the following: (e) Each time the controlled substance is to be taken or administered. 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 transcribe the resident's controlled substances as ordered, for one of two resident's included in the sample. (Resident #2) The finding includes: During the entrance interview with the qualified intellectual disabilities professional (QIDP) on July 11, 2013, at 10:15 a.m. revealed Resident #2 was prescribed psychotropic medications and had Behavior Support Plan (BSP) to manage her maladaptive behaviors. Review of Resident #2's medical record on July 11, 2013, at 5:09 p.m. revealed a physician's order for Ativan 0.5 milligram (mg) every morning (q am) and Ativan 1 mg (at bedtime) q hs. Review of Resident #2's "controlled medication utilization record" on July 12, 2013, at 1:31 p.m. revealed the resident was administered Ativan 1 mg q am from September 1, 2012, through September 19, 2012 instead of 0.5 mg every	I 479		

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1479	<p>Continued From page 4</p> <p>morning. Review of the resident's controlled medication utilization record also revealed the resident was administered Ativan 0.5 mg at bedtime instead of every morning from September 1, 2012, through September 19, 2012</p> <p>At the time of the survey, the GHID's nursing staff failed to ensure Resident #2 was administered Ativan 0.5 mg q am every morning and Ativan 1 mg at bedtime as ordered.</p> <p>It should be noted that the resident's September 2012's MAR was not available for review.</p>	1479	See Tag # 1474.	8-26-13