

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

PRINTED: 05/03/2013
FORM APPROVED
OMB NO. 0938-0391

DOH Received 5/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2013
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>On March 31, 2013, at 4:30 p.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), received notification of a medication error. According to the e-mail notification, the nurse responsible for administering evening medication, on March 30, 2013, did not report for duty, therefore; all of the clients residing in the facility did not receive their evening medications. In addition, on April 9, 2013, the OCQAID received an incident report via facsimile that reflected an incident that occurred on April 4, 2013, involving Client #1. According to the incident report, Client #1 was observed to be unresponsive at the dinner table. She was transported to the emergency room via ambulance and subsequently was admitted to the hospital. The OCQAID initiated an onsite investigation on April 10, 2013, to evaluate the facility's compliance with both Federal participation and local licensure requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The findings of the investigation were based on interviews with direct care staff, nursing staff and management staff, the review of medical and administrative records, as well as a review of the facility's incident management reporting system. During the process of the investigation, it was revealed that the facility staff failed to obtain medical services timely in order to address a client's change in health status (unresponsiveness). Additionally, the facility failed to ensure the availability of management/nursing staff during a critical incident. Based on this information, it was concluded that</p>	W 000	<ol style="list-style-type: none"> The direct care staff and nurses were trained on change of condition and signs and symptoms of illness for Client #1's specific issues...4-12-13 Additionally, staff and nurses received training on the above topics in a more general manner focusing on the appropriate reactions that are universal for anyone or any situation...4-12-13 Procedures for appropriately contacting 911 and managing the person safely while waiting for 911 supports to arrive were also taught during the training...4-12-13 The strategies outlined in the updated HMCP for Client #1 were also covered during the training session...4-12-13 Documentation for all of the above training was submitted to licensing...5-13-13 The resident specific safety protocol for Client #1 was developed and staff were trained on its strategies...4-12-13 An emergency contact guide was developed to ensure that staff are instructed on proper notifications in emergency situations. Staff were trained on the guide...4-12-13 The guide has been posted in the Recreation Room and all staff have been made aware of where it is posted...4-12-13 As indicated above staff have been trained on the modifications in the HMCP for Client #1 and all of the other required areas...4-12-13 Nurses were trained...4-13-13 One LPN remains outstanding and she is scheduled to be trained...5-11-13 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen Smythe for Evette Moran, DPA</i>	TITLE ODDP	(X6) DATE 5/23/13
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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 000	<p>Continued From page 1</p> <p>conditions existed that posed an immediate and serious threat to the health and safety of the clients that resided in the facility. On April 12, 2013, at 1:05 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. On April 12, 2013, at 5:00 p.m. the administrator submitted a plan to remove the IJ, however the plan was not accepted as it failed to include how nursing delivery was to be addressed. At 6:15 p.m. on April 12, 2013, the administrator submitted an addendum to the plan to address the IJ. The plan submitted consisted of the following:</p> <ol style="list-style-type: none"> 1. The direct care staff and nurses will be trained on the facility's change in condition plan and signs and symptoms for Client #1 including procedures for contacting 911. A protocol for Client #1 related to management of medical concerns that require 911 services and revision of Client #1's health management care plan (HMCP) to identify when 911 should be called will be included. The direct care staff and nursing staff will receive training on April 12, 2013, April 13, 2013 with a follow-up training on April 20, 2013. 2. Training of staff related to how to manage an individual (Client #1), safely while awaiting 911 services. The individual specific protocol developed for Client #1, will outline safety measures for supporting the client. The direct care staff and nurses will be trained on April 12, 2013 and April 13, 2013. 3. A formal written procedure will be put in place to guide staff in insuring that notifications are made timely to ensure the health and safety of the individuals supported. The guide for notification will identify for staff the procedure to follow. The guide for emergency contacts will be developed on April 12, 2013. The direct care staff 	W 000		
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W 000	Continued From page 2 and nurses will be trained on April 12, 2013, April 13, 2013 and April 16, 2013. 4. Client #1's HMCP was revised on April 12, 2013, to identify specific concerns related to the client's medical condition, specifically recurrent concerns that may require 911 support. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013 and April 15, 2013. 5. Effective immediately, registered nurse (RN) #1 and liscensed practical nurse (LPN) #1 will no longer continue a working relationship with MTS. DON #1 along with her nursing designee will provide nursing supports to the 55 th Street home. The immediate jeopardy was lifted on April 12, 2013, at 6:50 p.m. The facility however, remained out of compliance with the condition of participation in Health Care Services.	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff implemented established protocols to make certain clients received timely emergency services, for one of one client in the investigation (Client #1). The findings include: The facility failed to ensure the direct care staff implemented its General Administration Policy regarding serious illness and trauma as	W 149	Both the RN and LPN have been terminated for failure to follow MTS policy for appropriately addressing emergency situations and an individual's change in condition...4-12-13 The RN currently covering the home will be trained by the DON on emergency response, change of condition and the specific (new) protocols for Client #1...5-11-13 All staff and all nurses serving the home have been trained on emergency response with the exception of one nurse that will be trained by...5-11-13	

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W 149	<p>Continued From page 3 evidenced below:</p> <p>Interview with direct care staff (DCS) #1 on April 10, 2013, at approximately 11:00 a.m. revealed that on April 4, 2013, Client #1 was picked up from the day program at approximately 2:15 p.m. According to DCS #1, Client #1 was fine. The client received a snack, medication and dinner without incident. After dinner, between 6:00 p.m. and 6:30 p.m., Client #1 appeared to be sleeping at the table. Staff #1 called the client's name and asked the client if she was ok. Client #1 gave no response. After not receiving a response, Staff #2 and DCS #3 assisted Client #1 to the bathroom and gave her a shower. DCS #1 called the registered nurse (RN) #1 twice and the director of nursing (DON) #1 twice and innitially received no answer. Eventually, at approximately 6:30 p.m., RN #1 called the facility. DCS #1 informed RN #1 of Client #1's condition. RN #1 instructed the staff to lay Client #1 down and watch over her to see if they get a response from the client. RN #1 told DCS #1 that she would call back. The house manager (HM) #1 called the facility while Staff #1 was speaking to RN #1. HM #1 was informed of the instructions given by RN #1 but overruled those instructions and directed the DCS #1 to call 911.</p> <p>Interview with DCS #2 on April 10, 2013, at 2:22 p.m. corroborated the accounts made by DCS #1. DCS #2 stated that Client #1's eyes opened a little bit while in the shower but then closed. When asked if Client #1 was able to walk to the bathroom, DCS #2 stated that Client #1's gait was very unsteady.</p> <p>Review of the facility's policy entitled, "Signs and</p>	W 149		
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W 149	<p>Continued From page 4</p> <p>Symptoms: Just Not Right" on April 12, 2013, at approximately 4:00 p.m., stated that the staff was directed to call 911 if they noticed that "the person won't wake up." In addition, the facility had a "General Administration Policy" that documented "some conditions are of such magnitude that immediate transport to the emergency room is warranted. Direct Support Staff should call 911 immediately if the following conditions happen, then notify nursing. Those conditions include but are not limited to . . . loss of consciousness . . ."</p> <p>Interview with the director of nursing (DON) #1, on April 12, 2013 at approximately 11:00 a.m. revealed that the staff should have called 911 when Client #1 was observed being unresponsive.</p>	W 149		
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that the direct care staff was trained to competently perform in an emergency situation involving, one of one client in the investigation. (Client #1)</p> <p>The finding includes:</p> <p>Interview with Direct Care Staff (DCS) #1 on April 10, 2013, at approximately 11:00 a.m. revealed, that on April 4, 2013, that he/she witnessed an</p>	W 189	<p>The staff were trained on the signs and symptoms policy and protocols during the completion of Phase I training which was completed for all incumbent staff as mandated by DDS and is provided to new hires during their four- day orientation training which must be completed prior to starting work...5-12-13 (See: Attached training documentation)</p>	

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W 189	<p>Continued From page 5</p> <p>incident involving Client #1. According to DCS #1, Client #1 observed to be unresponsive on the evening of April 4, 2013. DCS #1 revealed that the client was given a shower, although unresponsive, in an effort to arouse her. After the shower, Client #1 was still noted to be unresponsive. Concurrent with the shower given to Client #1 by DCS #2 and #3, DCS #1 attempted to contact the facility's nursing personnel, registered nurse (RN) #1 and the director of nursing (DON) #1. DCS #1's initial attempts proved unsuccessful. It should be noted that the facility's staff did not immediately initiate a call to obtain emergency medical services to address Client #1's decline in health status.</p> <p>Review of the facility's policy entitled, "Signs and Symptoms: Just Not Right " on April 12, 2013, at approximately 4:00 p.m., stated that the staff was directed to call 911 if they noticed that " the person won't wake up." In addition, the facility had a "General Administration Policy" that documented "some conditions are of such magnitude that immediate transport to the emergency room is warranted. Direct Support Staff should call 911 immediately if the following conditions happen, then notify nursing. Those conditions include but are not limited to . . . loss of consciousness . . ."</p> <p>Interview with the Director of Nursing (DON) #1, on April 12, 2013 at approximately 11:00 a.m. revealed that the staff should have called 911 when Client #1 was observed being unresponsive.</p> <p>Interview with the QIPD on April 19, 2013, at approximately 2:00 p.m. however, revealed that she could not recall if the staff had received</p>	W 189		
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W 189	Continued From page 6 training on the policy. Review of the training records made available at the time of the investigation, failed to show evidence that the staff had been trained on this policy.	W 189		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to make certain that clients were assessed in accordance with their needs [See W322]; failed to provide nursing services in accordance with client's needs [See W331] and failed to administer medication in accordance with physician's orders [See W368]. The effects of these systematic practices resulted in the demonstrated failures of the facility to provide health care services.	W 318	See responses for W322, W331 and W368 Staff will be retrained on the bowel movement protocol for Client #1 to ensure that they understand the need to notify nursing if Client #1 does not have a bowel movement for 2 consecutive days...5-12-13 The Facility Manager will serve as the point person for reporting to nursing and will check the data daily to ensure accurate and timely reporting...5-12-13 *It should be noted that Client #1 had a bowel movement on 3-15-13, the day she was given the PRN medication; in fact, she had two (See: attached bowel movement sheets)...5-1-13 The QJDP will meet with the day program to ensure that the home receives data daily regarding the bowel movements of Client #1. Currently, the day program provides the data weekly which is insufficient for tracking the two-day timeline...5-15-13	

W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients received health care services in accordance with their identified needs for five of five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)	W 322	The medication nurse failed to follow MTS' established protocol has been replaced...5-1-13 The LPN should have called the DON or RN directly to inform them The DON has retrained staff on the MTS protocol to address potential late medication pass situations or potential to miss medication passing...4-13-13 The DON will do expanded training on the subject by...5-12-13 The new medication LPN has been trained on the proper protocol for notification of intent not to pass and other key considerations...4-20-13	
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W 322	<p>Continued From page 7 The findings include:</p> <p>1. The facility failed to ensure the effective management of Client #1's bowel elimination.</p> <p>a. Interview with the Incident Management Coordinator (IMC) #1, on April 10, 2013, at 10:16 a.m., revealed that Client #1 was admitted to the hospital on April 4, 2013, after being observed unresponsive at the group home. Client #1 was discharged on April 9, 2013. The discharge diagnosis included elevated white blood cell count (WBC) and constipation.</p> <p>Review of the client's Resident Care Flow Record (RCFR) on April 12, 2013, at approximately 12:36 p.m. revealed that the staff maintained documentation of the frequency of Client #1's bowel movements (BM). In addition, the staff was directed that if the client did not have a BM in two (2) days to contact the nurse the morning of the third day. Further review of the RCFR revealed that Client #1 did not have a BM from March 12, 2013 through March 14, 2013. Review of client #1's medication administration record (MAR) on April 12, 2013, at 12:00 p.m. revealed the client was administered her prescribed Senna Plus 8.6 milligran (mg)/500 mg constipation medication on March 13, 2013. Continued review of the MAR however failed to provide documentation on the medications effectiveness. Additionally, review of Client #1's nursing notes on April 12, 2013, at 12:00 p.m. failed to provide evidence that indicated nursing personnel had assessed the client's gastrointestinal system (i.e. auscultation and palpation).</p> <p>It should be noted that continued review of the</p>	W 322	<p>Staff will be retrained on the bowel movement protocol for Client #1 to ensure that they understand the need to notify nursing if Client #1 does not have a bowel movement for 2 consecutive days...5-12-13 The Facility Manager will serve as the point person for reporting to nursing and will check the data daily to ensure accurate and timely reporting...5-12-13</p> <p>*It should be noted that Client #1 had a bowel movement on 3-15-13, the day she was given the PRN medication; in fact, she had two (See: attached bowel movement sheets)...5-1-13</p> <p>The QIDP will meet with the day program to ensure that the home receives data daily regarding the bowel movements of Client #1. Currently, the day program provides the data weekly which is insufficient for tracking the two-day timeline...5-15-13</p> <p>The DON will ensure that the RN covering is trained to monitor whether a bowel movement occurs after the PRN medication is given and to document her findings and follow up in the nursing notes...5-11-13</p>	
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W 322	Continued From page 8 client's medical record revealed that the client did not have a BM until March 15, 2013. b. Review of Client #1's MAR's on April 12, 2013, at 12:12 p.m. revealed that on March 25, 2013, Client #1 received Senna Plus for constipation. According to the BM records the client had not had a BM since March 23, 2013. Review of the nursing notes on April 12, 2012, at approximately 1:00 p.m., however did not reveal that an assessment of Client #1's gastrointestinal system was completed. There was also no evidence that the nursing staff has assessed the effectiveness of Client #1's bowel movement medication regimen. Interview with DON #1 on April 12, 2013, at approximately 12:45 p.m., revealed that the nurses should have assessed the client's gastrointestinal system prior to administering the medication and again after the medication was administered to ensure the client had a bowel movement. At the time of the investigation the facility failed to ensure the provision of general care as it related to the management of Client #1's BM.	W 322			
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the nursing staff provided appropriate instructions to the direct care staff in an emergency situation and failed to ensure nursing services in accordance with standard	W 331		1. The RN and LPN involved have been terminated and replaced...5-1-13	

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W 331	<p>Continued From page 9</p> <p>nursing practices for five of five clients residing in the facility. (Clients #1, #2, #3, # 4 and #5)</p> <p>The findings include:</p> <p>On March 31, 2013, at 4:30 p.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), received notification of a medication error. According to the e-mail notification, the nurse responsible for administering evening medication, on March 30, 2013, did not report for duty; therefore, all of the clients residing in the facility did not receive their evening medications. In addition, on April 9, 2013, the OCQAID received an incident report via facsimile that reflected that an incident that occurred on April 4, 2013 involving Client #1. According to the incident report, Client #1 was observed to be unresponsive at the dinner table. She was transported to the emergency room via ambulance, and subsequently admitted to the hospital.</p> <p>Information obtained during the investigation revealed the following:</p> <p>1. The facility's nursing staff failed to provide appropriate instructions to the direct care staff (DCS) in an emergency situation as evidenced below:</p> <p>Interview with DCS #1 on April 10, 2013, at 11:00 a.m. revealed that after dinner, between 6:00 p.m. and 6:30 p.m., Client #1 appeared to be sleeping at the table. DCS #1 approached Client #1, called her name and shook her shoulders. After not receiving a response, DCS #2 and DCS #3 assisted Client #1 to the bathroom and gave</p>	W 331	<p>The direct care staff and nurses were trained on change of condition and signs and symptoms of illness for Client #1's specific issues...4-12-13</p> <p>Additionally, staff and nurses received training on the above topics in a more general manner focusing on the appropriate reactions that are universal for anyone or any situation...4-12-13</p> <p>Procedures for appropriately contacting 911 and managing the person safely while waiting for 911 supports to arrive were also taught during the training...4-12-13</p> <p>The strategies outlined in the updated HMCP for Client #1 were also covered during the training session...4-12-13</p> <p>Documentation for all of the above training was submitted to licensing...5-13-13</p> <p>The resident specific safety protocol for Client #1 was developed and staff were trained on its strategies...4-12-13</p> <p>An emergency contact guide was developed to ensure that staff are instructed on proper notifications in emergency situations. Staff were trained on the guide...4-12-13</p> <p>The guide has been posted in the Recreation Room and all staff have been made aware of where it is posted...4-12-13</p> <p>As indicated above staff have been trained on the modifications in the HMCP for Client #1 and all of the other required areas...4-12-13</p> <p>Nurses were trained...4-13-13</p> <p>One LPN remains outstanding and she is scheduled to be trained...5-11-13</p>		

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OMB NO. 0938-0391

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W 331	<p>Continued From page 10</p> <p>her a shower in an effort to arouse the client. Concurrently as Client #1 was being showered, DCS #1 called the registered nurse (RN) #1 twice and the director of nursing (DON) #1 twice but, initially received no answer. Eventually, at approximately 6:30 p.m., RN #1 called the facility. DCS #1 informed RN #1 of Client #1's condition. RN #1 instructed the staff to lay Client #1 down and watch over her to see if they get a response from the client. RN #1 further told DCS #1 that she would call back. Continued interview with DCS #1 revealed that while she was on the phone with RN #1, the house manager (HM) #1 called the facility. After informing HM #1 of Client #1's condition and of the instructions given to her by RN #1, HM #1 overruled RN #1's instructions and directed DCS #1 to call 911.</p> <p>According to DCS #1, licensed practical nurse (LPN) #1 called the facility shortly after emergency services was called to inquire about Client #1's condition. After informing LPN #1 about Client #1's condition, LPN #1 asked Staff #1 why emergency medical services (EMS) was called. LPN #1 reportedly stated that "all the staff needed to do was to put the client in the bed and monitor her condition." DCS #1 further indicated that when EMS arrived to the facility, they attempted to arouse Client #1 by calling her name, shaking her, and placing ammonia under her nose. There was still no response.</p> <p>Interview with LPN #1 on April 12, 2013, at 4:40 p.m. revealed that on April 4, 2013, she arrived to the facility at 5:00 p.m. to administer medications. Client #1 was fine at the time her medications were administered. Approximately one hour after leaving the facility, RN #1 called LPN #1 and</p>	W 331			

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W 331	<p>Continued From page 11</p> <p>asked her how Client #1 was doing when she administered medication. LPN #1 responded that Client #1 was fine. RN #1 told LPN #1 that Staff #1 informed her that Client #1 was lethargic. After being informed of the client's condition, LPN #1 called the facility to inquire about the client's status. DCS #1 informed LPN #1 that Client #1 was lethargic and sleepy. LPN #1 stated that DCS #1 informed her that EMS had been called and instructed the staff to monitor the client and they (EMS) would call the facility back. According to LPN #1, however, she told the staff to transport the client to the emergency room in the company van.</p> <p>Interview with a Fire and EMS Communications personnel (FEMS) #1 on April 19, 2013, at 10:48 a.m. revealed that it is not the policy of D.C. Fire and EMS to tell a resident to monitor a person in lieu of sending a unit to the facility. The operator would have instructed the caller to monitor the patient and if the condition changed, to call back to inform EMS of the change just in case a different unit; (either basic or advanced) needed to be dispatched.</p> <p>Review of the facility's policy entitled, "Signs and Symptoms: Just Not Right" on April 12, 2013, at approximately 4:00 p.m., documented that the staff are to call 911 if they notice that "the person won't wake up." In addition, the facility had a "General Administration Policy" that documented "some conditions are of such magnitude that immediate transport to the emergency room is warranted. Direct Support Staff should call 911 immediately if the following conditions happen, then notify nursing. Those conditions include but are not limited to . . . loss of consciousness . . .".</p>	W 331		
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W 331	Continued From page 12 At the time of this incident, the nursing staff failed to provide appropriate instructions to the staff to address Client #1's unresponsive episode. 2. The facility failed to ensure nursing services in accordance with standard nursing practices. Interview with the incident management coordinator (IMC) #1, on April 10, 2013, at approximately 10:16 a.m., revealed that Client #1 was admitted to the hospital on April 4, 2013, after being observed unresponsive at the group home. Client #1 was discharged on April 9, 2013. The discharge diagnosis included elevated white blood cell count (WBC) and constipation. a. Review of the client's Resident Care Flow Record (RCFR) on April 12, 2013, at approximately 12:36 p.m. revealed that the staff maintained documentation of the frequency of Client #1's bowel movements (BM). In addition, the staff was directed that if the client did not have a BM in two (2) days to contact the nurse the morning of the third day. Further review of the RCFR revealed that Client #1 did not have a BM from March 12, 2013 through March 14, 2013. Review of Client #1's medication administration record (MAR) on April 12, 2013, at 12:00 p.m. revealed the client was administered her prescribed Senna Plus 8.6 milligram (mg)/500 mg constipation medication on March 13, 2013. Continued review of the MAR however failed to provide documentation on the medication's effectiveness. Additionally, review of Client #1's nursing notes on April 12, 2013, at 12:10 p.m. failed to provide evidence that indicated nursing personnel had assessed the client's	W 331	2. Staff will be retrained on the bowel movement protocol for Client #1 to ensure that they understand the need to notify nursing if Client #1 does not have a bowel movement for 2 consecutive days...5-12-13 The Facility Manager will serve as the point person for reporting to nursing and will check the data daily to ensure accurate and timely reporting...5-12-13 *It should be noted that Client #1 had a bowel movement on 3-15-13, the day she was given the PRN medication; in fact, she had two (See: attached bowel movement sheets)...5-1-13 The QIDP will meet with the day program to ensure that the home receives data daily regarding the bowel movements of Client #1. Currently, the day program provides the data weekly which is insufficient for tracking the two-day timeline...5-15-13 The DON will ensure that the RN covering is trained to monitor whether a bowel movement occurs after the PRN medication is given and to document her findings and follow up in the nursing notes...5-11-13	
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W 331	<p>Continued From page 13 gastrointestinal system (i.e. auscultation and palpation).</p> <p>It should be noted that continued review of the client's medical record revealed that the client did not have a BM until March 15, 2013.</p> <p>b. Review of Client #1's MAR's on April 12, 2013, at 12:12 p.m. revealed that on March 25, 2013, Client #1 received Senna Plus for constipation. According to the BM records, the client had not had a BM since March 23, 2013. Review of the nursing notes on April 12, 2012, at approximately 1:00 p.m., however did not reveal that an assessment of the client's gastrointestinal system was completed. There was also no evidence that the nursing staff had assessed the effectiveness of Client #1's bowel movement medication regimen.</p> <p>Interview with DON#1 on April 12, 2013, at approximately 12:45 p.m., revealed that the nurses should have assessed the client's gastrointestinal system prior to administering the medication and again after the medication was administered to ensure the client had a bowel movement.</p> <p>At the time of the investigation, the facility failed to ensure nursing personnel provided services related to the maintenance of Client #1's bowel health as determined by her needs.</p> <p>3. The facility nursing staff failed to ensure medications were administered according to physician's orders as evidenced below:</p> <p>Review of the facility's incident reports and</p>	W 331	<p>3. The medication nurse failed to follow MTS' established protocol has been replaced...5-1-13</p> <p>The LPN should have called the DON or RN directly to inform them The DON has retrained staff on the MTS protocol to address potential late medication pass situations or potential to miss medication passing...4-13-13 The DON will do expanded training on the subject by...5-12-13</p> <p>The new medication LPN has been trained on the proper protocol for notification of intent not to pass and other key considerations...4-20-13</p>	
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W 331	<p>Continued From page 14</p> <p>corresponding investigation reports on April 10, 2013 at 3:30 p.m. revealed that on March 30, 2013 the licensed practical nurse (LPN) responsible for passing medications did not arrive to the facility.</p> <p>Interview with LPN #2 (medication nurse) on April 18, 2013, at 12:30 p.m. revealed that she communicated her need to be out of town a week in advance. She stated that she e-mailed and texted DON #1 to remind her that she would be out of town. LPN #2 stated that DON #1 responded "ok" to her e-mail. According to LPN #2, she was made aware of the medication error when she arrived back in town.</p> <p>Review of the e-mail trail from LPN #2 and DON #1 on April 18, 2013, revealed an e-mail to DON #1 from LPN #2 dated March 3, 2013. The e-mail reflected that LPN #2 would be out of town on "March 29, 2012 through March 1 2013."</p> <p>According to LPN #2 she revealed that the e-mail mistakenly identified March 1, 2013 instead of April 1, 2013. There was no evidence that DON #1 responded to this e-mail.</p> <p>Interview with DON #1 on April 12, 2013, at approximately 11:30 a.m., acknowledged that LPN #2 sent her an e-mail indicating that she would be out of town. Continued discussion with DON #1 was held to determine if there was a policy to address the issue of when and who the nurse should call in the event that she/he cannot administer medication as scheduled. DON #1 stated that the nurse should have called and spoken with the nurse coordinator or DON #1. DON #1 further indicated that after the medication error in January 2013 (when there was no nurse to administer medications), an administrative policy update was developed dated</p>	W 331		
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W 331	<p>Continued From page 15</p> <p>February 5, 2013. The update instructed the nurses to provide notification in writing at least seven (7) days in advance when requesting time off. In the event of an emergency, the nurse was instructed to speak with the nurse coordinator for the home so that coverage could be obtained. At the time of the investigation, the facility failed to ensure nursing coverage to make certain client's received their prescribed medications. (See also W368)</p> <p>Based on the aforementioned information, it was concluded that conditions existed that posed an immediate and serious threat to the health and safety of the clients that resided in the facility. On April 12, 2013, at 1:05 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. On April 12, 2013, at 5:00 p.m. the administrator submitted a plan to remove the IJ; however the plan was not accepted as it failed to include how nursing delivery was to be addressed. At 6:15 p.m. on April 12, 2013, the administrator submitted an addendum to the plan to address the IJ. The plan submitted consisted of the following:</p> <p>The direct care staff and nurses will be trained on the facility's change in condition plan and signs and symptoms for Client #1 including procedures for contacting 911. A protocol for Client #1 related to management of medical concerns that require 911 services and revision of Client #1's health management care plan (HMCP) to identify when 911 should be called will be included. The direct care staff and nursing staff will receive training on April 12, 2013, April 13, 2013 with a follow-up training on April 20, 2013.</p> <p>Training of staff related to how to manage an</p>	W 331		
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W 331	Continued From page 16 individual (Client #1), safely while awaiting 911 services. The individual specific protocol developed for Client #1, will outline safety measures for supporting the client. The direct care staff and nurses will be trained on April 12, 2013, and April 13, 2013. A formal written procedure will be put in place to guide staff in insuring that notifications are made timely to ensure the health and safety of the individuals supported. The guide for notification will identify for staff the procedure to follow. The guide for emergency contacts will be developed on April 12, 2013. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013 and April 16, 2013. Client #1's HMCP was revised on April 12, 2013, to identify specific concerns related to the client's medical condition, specifically recurrent concerns that may require 911 support. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013, and April 15, 2013. Effective immediately, RN #1 and LPN #1 will no longer continue a working relationship with MTS. DON #1 along with her nursing designee will provide nursing supports to the 55th Street home. The immediate jeopardy was lifted on April 12, 2013, at 6:50 p.m.	W 331			
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 interview and record review, the facility failed to ensure medications were administered according to physician's orders for five of five	W 368			

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W 368	<p>Continued From page 17</p> <p>clients residing in the facility. (Clients #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>Interview with the incident management coordinator (IMC) #1 on April 10, 2013, at 11:30 a.m. revealed that on March 30, 2013, the clients residing in the facility did not receive their evening medications as prescribed. Review of the medical records on April 12, 2013, revealed the clients did not receive the following medications:</p> <ol style="list-style-type: none"> Client #1 did not receive her prescribed Gas X, 80 milligram (mg) for gas and vitamin E, 400 units for tardive dyskinesia. Client #2 did not receive her prescribed Chlorpromazine Hcl 100 mg, for obsessive compulsive disease, Klonopin 2 mg, Lacrilube ointment for dry eyes, and Simvastatin 20 mg for high cholesterol. Client #3 did not receive her prescribed Miralax powder for constipation, Risperdal 3 mg for aggression, Tylenol 500 mg for arthritis, Antacid with calcium Carbonate for nutritional bulk supplement, Tegretol 200 mg for seizures disorder, Anafranil 125 mg for bipolar, Enulose for constipation, Famotidine 20 mg for gastritis, and Hydrogen peroxide/mineral oil for ear wax control. Client #4 did not receive her prescribed Haldol 10 mg for psychosis, Neurontin 100 mg for seizure disorder, Coreg 12.5 mg for hypertension, and Calcium carbonate 60 mg supplement. Client #5 did not receive her prescribed Calcium with vitamin D 600 mg - 400 mg for osteoporosis, Debrox ear drops for cerumen control and Miralax powder for constipation. <p>The facility failed to ensure client's received their</p>	W 368	<ol style="list-style-type: none"> The medication nurse failed to follow MTS' established protocol has been replaced...5-1-13 The LPN should have called the DON or RN directly to inform them The DON has retrained staff on the MTS protocol to address potential late medication pass situations or potential to miss medication passing...4-13-13 The DON will do expanded training on the subject by...5-12-13 <p>The new medication LPN has been trained on the proper protocol for notification of intent not to pass and other key considerations...4-20-13</p> <p>The medication administration record will be reviewed at minimum weekly by the QIDP or RN and daily by the medication passing nurses to ensure all medications are given and properly documented as prescribed...5-1-13 The QIDP will notify the DON of any issues discovered...5-1-13</p>	
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W 368	Continued From page 18 medications in accordance with their physician's orders.	W 368		
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Health Regulation & Licensing Administration

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1 000	<p>INITIAL COMMENTS</p> <p>On March 31, 2013, at 4:30 p.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), received notification of a medication error. According to the e-mail notification, the nurse responsible for administering evening medication, on March 30, 2013, did not report for duty, therefore; all of the clients residing in the Group home for person's with intellectual disabilities (GHPID) did not receive their evening medications. In addition, on April 9, 2013, the OCQAID received an incident report via facsimile that reflected an incident that occurred on April 4, 2013, involving Resident #2. According to the incident report, Resident #2 was observed to be unresponsive at the dinner table. She was transported to the emergency room via ambulance and subsequently was admitted to the hospital.</p> <p>The OCQAID initiated an onsite investigation on April 10, 2013, to evaluate the GHPID's compliance with both Federal participation and local licensure requirements for Intermediate Care Facilities for Individuals with intellectual Disabilities (ICFID).</p> <p>The findings of the investigation were based on interviews with direct care staff, nursing staff and management staff, the review of medical and administrative records, as well as a review of the GHPID's incident management reporting system. During the process of the investigation, it was revealed that the GHPID staff failed to obtain medical services timely in order to address a client's change in health status (unresponsiveness). Additionally, the GHPID failed to ensure the availability of management/nursing staff during a critical incident.</p> <p>Based on this information, it was concluded that</p>	1 000	<ol style="list-style-type: none"> The direct care staff and nurses were trained on change of condition and signs and symptoms of illness for Client #1's specific issues...4-12-13 <p>Additionally, staff and nurses received training on the above topics in a more general manner focusing on the appropriate reactions that are universal for anyone or any situation...4-12-13</p> <p>Procedures for appropriately contacting 911 and managing the person safely while waiting for 911 supports to arrive were also taught during the training...4-12-13</p> <p>The strategies outlined in the updated HMCP for Client #1 were also covered during the training session...4-12-13</p> <p>Documentation for all of the above training was submitted to licensing...5-13-13</p> <ol style="list-style-type: none"> The resident specific safety protocol for Client #1 was developed and staff were trained on its strategies...4-12-13 An emergency contact guide was developed to ensure that staff are instructed on proper notifications in emergency situations. Staff were trained on the guide...4-12-13 <p>The guide has been posted in the Recreation Room and all staff have been made aware of where it is posted...4-12-13</p> <ol style="list-style-type: none"> As indicated above staff have been trained on the modifications in the HMCP for Client #1 and all of the other required areas...4-12-13 <p>Nurses were trained...4-13-13</p> <p>One LPN remains outstanding and she is scheduled to be trained...5-11-13</p>	
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Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maureen Smith for Evette Wood, DR.S*

TITLE: *QDDP*

(X6) DATE: *5/23/13*

STATE FORM 6899 BC9311 If continuation sheet 1 of 16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
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I 000	Continued From page 1 conditions existed that posed an immediate and serious threat to the health and safety of the clients that resided in the GHPID. On April 12, 2013, at 1:05 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. On April 12, 2013, at 5:00 p.m. the administrator submitted a plan to remove the IJ, however the plan was not accepted as it failed to include how nursing delivery was to be addressed. At 6:15 p.m. on April 12, 2013, the administrator submitted an addendum to the plan to address the IJ. The plan submitted consisted of the following: 1. The direct care staff and nurses will be trained on the GHPID's change in condition plan and signs and symptoms for Resident #2 including procedures for contacting 911. A protocol for Resident #2 related to management of medical concerns that require 911 services and revision of Resident #2's health management care plan (HMCP) to identify when 911 should be called will be included. The direct care staff and nursing staff will receive training on April 12, 2013, April 13, 2013 with a follow-up training on April 20, 2013. 2. Training of staff related to how to manage an individual (Resident #2), safely while awaiting 911 services. The individual specific protocol developed for Resident #2, will outline safety measures for supporting the client. The direct care staff and nurses will be trained on April 12, 2013 and April 13, 2013. 3. A formal written procedure will be put in place to guide staff in insuring that notifications are made timely to ensure the health and safety of the individuals supported. The guide for notification will identify for staff the procedure to follow. The guide for emergency contacts will be developed on April 12, 2013. The direct care staff and nurses will be trained on April 12, 2013, April	I 000		

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1000	Continued From page 2 13, 2013 and April 16, 2013. 4. Resident #2's HMCP was revised on April 12, 2013, to identify specific concerns related to the client's medical condition, specifically recurrent concerns that may require 911 support. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013 and April 15, 2013. 5. Effective immediately, registered nurse (RN) #1 and liscensed practical nurse (LPN) #1 will no longer continue a working relationship with MTS. DON #1 along with her nursing designee will provide nursing supports to the 55 th Street home. The immediate jeopardy was lifted on April12, 2013, at 6:50 p.m. The GHPID however, remained out of compliance with the condition of participation in Health Care Services.	1000		
1390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current " Outcome Performance Measures " from the " Council on Quality and Leadership in Support for People With Disabilities " (Council) and to the extent of funds appropriated for purposes of D.C. Law 2-137, as amended. This Statute is not met as evidenced by: Based on interview and record review, thegroup home for individuals with intellectual disabilities GHPID failed to ensure tje provision of nursing services to meet the residen's assessed needs for five of five residents in the GHPID. (Residents #1, #2, #3, #4 and #5)	1390	Both the RN and LPN have been terminated for failure to follow MTS policy for appropriately addressing emergency situations and an individual's change in condition...4-12-13 The RN currently covering the home will be trained by the DON on emergency response, change of condition and the specific (new) protocols for Client #1...5-11-13 All staff and all nurses serving the home have been trained on emergency response with the exception of one nurse that will be trained by...5-11-13	

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I 390	Continued From page 3 The findings include: 1. The facility's nursing staff failed to provide appropriate instructions to the direct care staff (DCS) in an emergency situation as evidenced below: Interview with DCS #1 on April 10, 2013, at 11:00 a.m. revealed that after dinner, between 6:00 p.m. and 6:30 p.m., Client #1 appeared to be sleeping at the table. DCS #1 approached Client #1, called her name and shook her shoulders. After not receiving a response, DCS #2 and DCS #3 assisted Client #1 to the bathroom and gave her a shower in an effort to arouse the client. Concurrently as Client #1 was being showered, DCS #1 called the registered nurse (RN) #1 twice and the director of nursing (DON) #1 twice but, initially received no answer. Eventually, at approximately 6:30 p.m., RN #1 called the facility. DCS #1 informed RN #1 of Client #1's condition. RN #1 instructed the staff to lay Client #1 down and watch over her to see if they get a response from the client. RN #1 further told DCS #1 that she would call back. Continued interview with DCS #1 revealed that while she was on the phone with RN #1, the house manager (HM) #1 called the facility. After informing HM #1 of Client #1's condition and of the instructions given to her by RN #1, HM #1 overruled RN #1's instructions and directed DCS #1 to call 911. According to DCS #1, licensed practical nurse (LPN) #1 called the facility shortly after emergency services was called to inquire about Client #1's condition. After informing LPN #1 about Client #1's condition, LPN #1 asked Staff #1 why emergency medical services (EMS) was called. LPN #1 reportedly stated that "all the staff	I 390			

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I 390	Continued From page 4 needed to do was to put the client in the bed and monitor her condition." DCS #1 further indicated that when EMS arrived to the facility, they attempted to arouse Client #1 by calling her name, shaking her, and placing ammonia under her nose. There was still no response. Interview with LPN #1 on April 12, 2013, at 4:40 p.m. revealed that on April 4, 2013, she arrived to the facility at 5:00 p.m. to administer medications. Client #1 was fine at the time her medications were administered. Approximately one hour after leaving the facility, RN #1 called LPN #1 and asked her how Client #1 was doing when she administered medication. LPN #1 responded that Client #1 was fine. RN #1 told LPN #1 that Staff #1 informed her that Client #1 was lethargic. After being informed of the client's condition , LPN #1 called the facility to inquire about the client's status. DCS #1 informed LPN #1 that Client #1 was lethargic and sleepy. LPN #1 stated that DCS #1 informed her that EMS had been called and instructed the staff to monitor the client and they (EMS) would call the facility back. According to LPN #1, however, she told the staff to transport the client to the emergency room in the company van. Interview with a Fire and EMS Communications personnel (FEMS) #1 on April 19, 2013, at 10:48 a.m. revealed that it is not the policy of D.C. Fire and EMS to tell a resident to monitor a person in lieu of sending a unit to the facility. The operator would have instructed the caller to monitor the patient and if the condition changed, to call back to inform EMS of the change just in case a different unit; (either basic or advanced) needed to be dispatched. Review of the facility's policy entitled, "Signs and	I 390			

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I 390	<p>Continued From page 5</p> <p>Symptoms: Just Not Right" on April 12, 2013, at approximately 4:00 p.m., documented that the staff are to call 911 if they notice that "the person won't wake up." In addition, the facility had a "General Administration Policy" that documented "some conditions are of such magnitude that immediate transport to the emergency room is warranted. Direct Support Staff should call 911 immediately if the following conditions happen, then notify nursing. Those conditions include but are not limited to . . . loss of consciousness . . .".</p> <p>At the time of this incident, the nursing staff failed to provide appropriate instructions to the staff to address Client #1's unresponsive episode.</p> <p>2. The facility failed to ensure nursing services in accordance with standard nursing practices.</p> <p>Interview with the incident management coordinator (IMC) #1, on April 10, 2013, at approximately 10:16 a.m., revealed that Client #1 was admitted to the hospital on April 4, 2013, after being observed unresponsive at the group home. Client #1 was discharged on April 9, 2013. The discharge diagnosis included elevated white blood cell count (WBC) and constipation.</p> <p>a. Review of the client's Resident Care Flow Record (RCFR) on April 12, 2013, at approximately 12:36 p.m. revealed that the staff maintained documentation of the frequency of Client #1's bowel movements (BM). In addition, the staff was directed that if the client did not have a BM in two (2) days to contact the nurse the morning of the third day. Further review of the RCFR revealed that Client #1 did not have a BM from March 12, 2013 through March 14, 2013. Review of Client #1's medication administration record (MAR) on April 12, 2013, at 12:00 p.m.</p>	I 390	<p>Staff will be retrained on the bowel movement protocol for Client #1 to ensure that they understand the need to notify nursing if Client #1 does not have a bowel movement for 2 consecutive days...5-12-13</p> <p>The Facility Manager will serve as the point person for reporting to nursing and will check the data daily to ensure accurate and timely reporting...5-12-13</p> <p>*It should be noted that Client #1 had a bowel movement on 3-15-13, the day she was given the PRN medication; in fact, she had two (See: attached bowel movement sheets)...5-1-13</p> <p>The QIDP will meet with the day program to ensure that the home receives data daily regarding the bowel movements of Client #1. Currently, the day program provides the data weekly which is insufficient for tracking the two-day timeline...5-15-13</p> <p>The DON will ensure that the RN covering is trained to monitor whether a bowel movement occurs after the PRN medication is given and to document her findings and follow up in the nursing notes...5-11-13</p>	
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I 390	<p>Continued From page 6</p> <p>revealed the client was administered her prescribed Senna Plus 8.6 milligram (mg)/500 mg constipation medication on March 13, 2013. Continued review of the MAR however failed to provide documentation on the medication's effectiveness. Additionally, review of Client #1's nursing notes on April 12, 2013, at 12:10 p.m. failed to provide evidence that indicated nursing personnel had assessed the client's gastrointestinal system (i.e. auscultation and palpation).</p> <p>It should be noted that continued review of the client's medical record revealed that the client did not have a BM until March 15, 2013.</p> <p>b. Review of Client #1's MAR's on April 12, 2013, at 12:12 p.m. revealed that on March 25, 2013, Client #1 received Senna Plus for constipation. According to the BM records, the client had not had a BM since March 23, 2013. Review of the nursing notes on April 12, 2012, at approximately 1:00 p.m., however did not reveal that an assessment of the client's gastrointestinal system was completed. There was also no evidence that the nursing staff had assessed the effectiveness of Client #1's bowel movement medication regimen.</p> <p>Interview with DON#1 on April 12, 2013, at approximately 12:45 p.m., revealed that the nurses should have assessed the client's gastrointestinal system prior to administering the medication and again after the medication was administered to ensure the client had a bowel movement.</p> <p>At the time of the investigation, the facility failed to ensure nursing personnel provided services related to the maintenance of Client #1's bowel</p>	I 390		
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I 390	<p>Continued From page 7</p> <p>health as determined by her needs.</p> <p>3. The facility nursing staff failed to ensure medications were administered according to physician's orders as evidenced below:</p> <p>Review of the facility's incident reports and corresponding investigation reports on April 10, 2013 at 3:30 p.m. revealed that on March 30, 2013 the licensed practical nurse (LPN) responsible for passing medications did not arrive to the facility.</p> <p>Interview with LPN #2 (medication nurse) on April 18, 2013, at 12:30 p.m. revealed that she communicated her need to be out of town a week in advance. She stated that she e-mailed and texted DON #1 to remind her that she would be out of town. LPN #2 stated that DON #1 responded "ok" to her e-mail. According to LPN #2, she was made aware of the medication error when she arrived back in town.</p> <p>Review of the e-mail trail from LPN #2 and DON #1 on April 18, 2013, revealed an e-mail to DON #1 from LPN #2 dated March 3, 2013. The e-mail reflected that LPN #2 would be out of town on "March 29, 2012 through March 1 2013." According to LPN #2 she revealed that the e-mail mistakenly identified March 1, 2013 instead of April 1, 2013. There was no evidence that DON #1 responded to this e-mail.</p> <p>Interview with DON #1 on April 12, 2013, at approximately 11:30 a.m., acknowledged that LPN #2 sent her an e-mail indicating that she would be out of town. Continued discussion with DON #1 was held to determine if there was a policy to address the issue of when and who the nurse should call in the event that she/he cannot administer medication as scheduled. DON #1 stated that the nurse should have called and</p>	I 390	<p>1. The medication nurse failed to follow MTS' established protocol has been replaced...5-1-13 The LPN should have called the DON or RN directly to inform them The DON has retrained staff on the MTS protocol to address potential late medication pass situations or potential to miss medication passing...4-13-13 The DON will do expanded training on the subject by...5-12-13</p> <p>The new medication LPN has been trained on the proper protocol for notification of intent not to pass and other key considerations...4-20-13</p> <p>The medication administration record will be reviewed at minimum weekly by the QIDP or RN and daily by the medication passing nurses to ensure all medications are given and properly documented as prescribed...5-1-13 The QIDP will notify the DON of any issues discovered...5-1-13</p>	

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I 390	Continued From page 8 spoken with the nurse coordinator or DON #1. DON #1 further indicated that after the medication error in January 2013 (when there was no nurse to administer medications), an administrative policy update was developed dated February 5, 2013. The update instructed the nurses to provide notification in writing at least seven (7) days in advance when requesting time off. In the event of an emergency, the nurse was instructed to speak with the nurse coordinator for the home so that coverage could be obtained. At the time of the investigation, the facility failed to ensure nursing coverage to make certain client's received their prescribed medications. (See also W368) Based on the aforementioned information, it was concluded that conditions existed that posed an immediate and serious threat to the health and safety of the clients that resided in the facility. On April 12, 2013, at 1:05 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. On April 12, 2013, at 5:00 p.m. the administrator submitted a plan to remove the IJ; however the plan was not accepted as it failed to include how nursing delivery was to be addressed. At 6:15 p.m. on April 12, 2013, the administrator submitted an addendum to the plan to address the IJ. The plan submitted consisted of the following: The direct care staff and nurses will be trained on the facility's change in condition plan and signs and symptoms for Client #1 including procedures for contacting 911. A protocol for Client #1 related to management of medical concerns that require 911 services and revision of Client #1's health management care plan (HMCP) to identify when 911 should be called will be included. The direct care staff and nursing staff will receive training on	I 390		
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I 390	Continued From page 9 April 12, 2013, April 13, 2013 with a follow-up training on April 20, 2013. Training of staff related to how to manage an individual (Client #1), safely while awaiting 911 services. The individual specific protocol developed for Client #1, will outline safety measures for supporting the client. The direct care staff and nurses will be trained on April 12, 2013, and April 13, 2013. A formal written procedure will be put in place to guide staff in insuring that notifications are made timely to ensure the health and safety of the individuals supported. The guide for notification will identify for staff the procedure to follow. The guide for emergency contacts will be developed on April 12, 2013. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013 and April 16, 2013. Client #1's HMCP was revised on April 12, 2013, to identify specific concerns related to the client's medical condition, specifically recurrent concerns that may require 911 support. The direct care staff and nurses will be trained on April 12, 2013, April 13, 2013, and April 15, 2013. Effective immediately, RN #1 and LPN #1 will no longer continue a working relationship with MTS. DON #1 along with her nursing designee will provide nursing supports to the 55th Street home. The immediate jeopardy was lifted on April 12, 2013, at 6:50 p.m.	I 390			
I 500	3523.1 RESIDENT'S RIGHTS 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.	I 500			

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I 500	<p>Continued From page 10</p> <p>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 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 three residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>Chapter 13, § 7-1305.05. Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly § 6-1965], and [483.460(g)(2)]</p> <p>(g) Each customer has the right to prompt and adequate medical attention for any physical ailments...</p> <p>1. The GHPID's nursing staff failed to provide appropriate instructions to the direct care staff (DCS) in an emergency situation as evidenced below:</p> <p>Interview with DCS #1 on April 10, 2013, at 11:00 a.m. revealed that after dinner, between 6:00 p.m. and 6:30 p.m., Resident #1 appeared to be sleeping at the table. DCS #1 approached Resident #1, called her name and shook her shoulders. After not receiving a response, DCS #2 and DCS #3 assisted Resident #1 to the bathroom and gave her a shower in an effort to arouse the resident. Concurrently as Resident #1 was being showered, DCS #1 called the registered nurse (RN) #1 twice and the director of</p>	I 500	<p>1. The RN and LPN involved have been terminated and replaced...5-1-13</p> <p>The direct care staff and nurses were trained on change of condition and signs and symptoms of illness for Client #1's specific issues...4-12-13 Additionally, staff and nurses received training on the above topics in a more general manner focusing on the appropriate reactions that are universal for anyone or any situation...4-12-13 Procedures for appropriately contacting 911 and managing the person safely while waiting for 911 supports to arrive were also taught during the training...4-12-13 The strategies outlined in the updated HMCP for Client #1 were also covered during the training session...4-12-13 Documentation for all of the above training was submitted to licensing...5-13-13</p> <p>The resident specific safety protocol for Client #1 was developed and staff were trained on its strategies...4-12-13 An emergency contact guide was developed to ensure that staff are instructed on proper notifications in emergency situations. Staff were trained on the guide...4-12-13 The guide has been posted in the Recreation Room and all staff have been made aware of where it is posted...4-12-13</p> <p>As indicated above staff have been trained on the modifications in the HMCP for Client #1 and all of the other required areas...4-12-13 Nurses were trained...4-13-13 One LPN remains outstanding and she is scheduled to be trained...5-11-13</p>	
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
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I 500	Continued From page 11 nursing (DON) #1 twice but, initially received no answer. Eventually, at approximately 6:30 p.m., RN #1 called the GHPID. DCS #1 informed RN #1 of Resident #1's condition. RN #1 instructed the staff to lay Resident #1 down and watch over her to see if they get a response from the resident. RN #1 further told DCS #1 that she would call back. Continued interview with DCS #1 revealed that while she was on the phone with RN #1, the house manager (HM) #1 called the GHPID. After informing HM #1 of Resident #1's condition and of the instructions given to her by RN #1, HM #1 overruled RN #1's instructions and directed DCS #1 to call 911. According to DCS #1, licensed practical nurse (LPN) #1 called the GHPID shortly after emergency services was called to inquire about Resident #1's condition. After informing LPN #1 about Resident #1's condition, LPN #1 asked Staff #1 why emergency medical services (EMS) was called. LPN #1 reportedly stated that "all the staff needed to do was to put the resident in the bed and monitor her condition." DCS #1 further indicated that when EMS arrived to the GHPID, they attempted to arouse Resident #1 by calling her name, shaking her, and placing ammonia under her nose. There was still no response. Interview with LPN #1 on April 12, 2013, at 4:40 p.m. revealed that on April 4, 2013, she arrived to the GHPID at 5:00 p.m. to administer medications. Resident #1 was fine at the time her medications were administered. Approximately one hour after leaving the GHPID, RN #1 called LPN #1 and asked her how Resident #1 was doing when she administered medication. LPN #1 responded that Resident #1 was fine. RN #1 told LPN #1 that Staff #1 informed her that Resident #1 was lethargic. After being informed	I 500	2. Staff will be retrained on the bowel movement protocol for Client #1 to ensure that they understand the need to notify nursing if Client #1 does not have a bowel movement for 2 consecutive days...5-12-13 The Facility Manager will serve as the point person for reporting to nursing and will check the data daily to ensure accurate and timely reporting...5-12-13 *It should be noted that Client #1 had a bowel movement on 3-15-13, the day she was given the PRN medication; in fact, she had two (See: attached bowel movement sheets)...5-1-13 The QIDP will meet with the day program to ensure that the home receives data daily regarding the bowel movements of Client #1. Currently, the day program provides the data weekly which is insufficient for tracking the two-day timeline...5-15-13 The DON will ensure that the RN covering is trained to monitor whether a bowel movement occurs after the PRN medication is given and to document her findings and follow up in the nursing notes...5-11-13 3. The medication nurse failed to follow MTS' established protocol has been replaced...5-1-13		

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I 500	<p>Continued From page 12</p> <p>of the resident 's condition, LPN #1 called the GHPID to inquire about the resident 's status. DCS #1 informed LPN #1 that Resident #1 was lethargic and sleepy. LPN #1 stated that DCS #1 informed her that EMS had been called and instructed the staff to monitor the resident and they (EMS) would call the GHPID back. According to LPN #1, however, she told the staff to transport the resident to the emergency room in the company van.</p> <p>Interview with a Fire and EMS Communications personnel (FEMS) #1 on April 19, 2013, at 10:48 a.m. revealed that it is not the policy of D.C. Fire and EMS to tell a resident to monitor a person in lieu of sending a unit to the GHPID. The operator would have instructed the caller to monitor the patient and if the condition changed, to call back to inform EMS of the change just in case a different unit; (either basic or advanced) needed to be dispatched.</p> <p>Review of the GHPID's policy entitled, "Signs and Symptoms: Just Not Right" on April 12, 2013, at approximately 4:00 p.m., documented that the staff are to call 911 if they notice that "the person won't wake up." In addition, the GHPID had a "General Administration Policy" that documented "some conditions are of such magnitude that immediate transport to the emergency room is warranted. Direct Support Staff should call 911 immediately if the following conditions happen, then notify nursing. Those conditions include but are not limited to . . . loss of consciousness . . .".</p> <p>At the time of this incident, the nursing staff failed to provide appropriate instructions to the staff to address Resident #1's unresponsive episode.</p> <p>2. The GHPID failed to ensure nursing services in</p>	I 500		
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I 500	<p>Continued From page 13</p> <p>accordance with standard nursing practices.</p> <p>Interview with the incident management coordinator (IMC) #1, on April 10, 2013, at approximately 10:16 a.m., revealed that Resident #1 was admitted to the hospital on April 4, 2013, after being observed unresponsive at the group home. Resident #1 was discharged on April 9, 2013. The discharge diagnosis included elevated white blood cell count (WBC) and constipation.</p> <p>a. Review of the resident's Resident Care Flow Record (RCFR) on April 12, 2013, at approximately 12:36 p.m. revealed that the staff maintained documentation of the frequency of Resident #1's bowel movements (BM). In addition, the staff was directed that if the resident did not have a BM in two (2) days to contact the nurse the morning of the third day. Further review of the RCFR revealed that Resident #1 did not have a BM from March 12, 2013 through March 14, 2013. Review of Resident #1's medication administration record (MAR) on April 12, 2013, at 12:00 p.m. revealed the resident was administered her prescribed Senna Plus 8.6 milligram (mg)/500 mg constipation medication on March 13, 2013. Continued review of the MAR however failed to provide documentation on the medication's effectiveness. Additionally, review of Resident #1's nursing notes on April 12, 2013, at 12:10 p.m. failed to provide evidence that indicated nursing personnel had assessed the resident's gastrointestinal system (i.e. auscultation and palpation).</p> <p>It should be noted that continued review of the resident's medical record revealed that the resident did not have a BM until March 15, 2013.</p> <p>b. Review of Resident #1's MAR's on April 12,</p>	I 500		
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1 500	Continued From page 14 2013, at 12:12 p.m. revealed that on March 25, 2013, Resident #1 received Senna Plus for constipation. According to the BM records, the resident had not had a BM since March 23, 2013. Review of the nursing notes on April 12, 2012, at approximately 1:00 p.m., however did not reveal that an assessment of the resident's gastrointestinal system was completed. There was also no evidence that the nursing staff had assessed the effectiveness of Resident #1's bowel movement medication regimen. Interview with DON#1 on April 12, 2013, at approximately 12:45 p.m., revealed that the nurses should have assessed the resident's gastrointestinal system prior to administering the medication and again after the medication was administered to ensure the resident had a bowel movement. At the time of the investigation, the GHPID failed to ensure nursing personnel provided services related to the maintenance of Resident #1's bowel health as determined by her needs. 3. The GHPID nursing staff failed to ensure medications were administered according to physician's orders as evidenced below: Review of the GHPID's incident reports and corresponding investigation reports on April 10, 2013 at 3:30 p.m. revealed that on March 30, 2013 the licensed practical nurse (LPN) responsible for passing medications did not arrive to the GHPID. Interview with LPN #2 (medication nurse) on April 18, 2013, at 12:30 p.m. revealed that she communicated her need to be out of town a week in advance. She stated that she e-mailed and texted DON #1 to remind her that she would	1 500			

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I 500	Continued From page 15 be out of town. LPN #2 stated that DON #1 responded "ok" to her e-mail. According to LPN #2, she was made aware of the medication error when she arrived back in town. Review of the e-mail trail from LPN #2 and DON #1 on April 18, 2013, revealed an e-mail to DON #1 from LPN #2 dated March 3, 2013. The e-mail reflected that LPN #2 would be out of town on "March 29, 2012 through March 1 2013." According to LPN #2 she revealed that the e-mail mistakenly identified March 1, 2013 instead of April 1, 2013. There was no evidence that DON #1 responded to this e-mail. Interview with DON #1 on April 12, 2013, at approximately 11:30 a.m., acknowledged that LPN #2 sent her an e-mail indicating that she would be out of town. Continued discussion with DON #1 was held to determine if there was a policy to address the issue of when and who the nurse should call in the event that she/he cannot administer medication as scheduled. DON #1 stated that the nurse should have called and spoken with the nurse coordinator or DON #1. DON #1 further indicated that after the medication error in January 2013 (when there was no nurse to administer medications), an administrative policy update was developed dated February 5, 2013. The update instructed the nurses to provide notification in writing at least seven (7) days in advance when requesting time off. In the event of an emergency, the nurse was instructed to speak with the nurse coordinator for the home so that coverage could be obtained. At the time of the investigation, the GHPID failed to ensure nursing coverage to make certain resident 's received their prescribed medications. (See also W368)	I 500		