

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

PRINTED: 04/18/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| W 262 | Continued From page 16 behaviors: self-injury, agitation, physical aggression and inappropriate sexual expression. The BSP was dated August 9, 2012, with effective dates of implementation identified as August 10, 2012 through August 9, 2013. Additional review of the BSP on March 26, 2013, at 2:00 p.m., revealed a section of the BSP entitled "Staffing Supports." The BSP included: "[Client #3's name] does not require one to one supervision. He should be provided 24 hour staffing supervision." An associated Human Rights Committee (HRC) form was also found in the record, dated August 9, 2012. It evinced review of the August 9, 2012 BSP. In a follow-up interview with the QIDP on March 26, 2013, at 4:35 p.m., she was asked when the highly restrictive intervention of one-to-one supervision was implemented; the QIDP replied "October." When the QIDP was asked if the facility's specially constituted committee had reviewed and approved any updates to this BSP, she explained the BSP had not been updated to include one-to-one supervision. There was no evidence of any HRC review of the new restriction. | W 262 | | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record | W 263 | | |

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| W 263 | <p>Continued From page 17</p> <p>review the facility's specially constituted committee failed to ensure written consent was obtained prior to the initiation of the restrictive practice of 1:1 supervision, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Upon entrance to the facility on March 25, 2013, at 8:05 a.m., Client #3 was observed sitting in the living room on a couch. A direct support staff (Staff #10) was noted to be sitting near to Client #3. Whenever Client #3 attempted to get up from the couch or leave the room Staff #10 would move to be with Client #3.</p> <p>During the entrance conference with the facility's qualified intellectual disabilities (QIDP, Staff #1) on March 25, 2013, beginning at 9:30 a.m., she stated that all clients living at the facility received one-to-one staffing. Except for Client #1, all the one-to-one supervision supports were in effect for client behavioral needs. The QIDP further stated that all clients had Behavior Support Plans (BSPs), there were no time-out rooms and restraints were not used at the facility.</p> <p>Per record review for Client #3 on March 26, 2013, beginning at 9:35 a.m., it was revealed Client #3 had a "one-to-one assignment book" with sheets documenting the level of supervision provided to Client #3, twenty four hours per day, seven days per week. Additionally, a reference BSP was available in the one-to-one assignment book for Client #3 identifying the following target behaviors: self-injury, agitation, physical aggression and inappropriate sexual expression. The BSP was dated August 9, 2012, with</p> | W 263 | <p>W263</p> <p>Concurrent with the HRC review, the legal guardian of Client #3 will be contacted, informed about the one-to-one support and asked to provide consent as soon as the psychologist revises the BSP...5-7-13</p> <p>In the process of meeting as a team and discussing all of the survey issues, the QA reinforced for the entire team, the necessity to complete these processes on a routine basis whenever a one-to-one staffing pattern is established, whenever a psychotropic drug regimen is established or modified and whenever a BSP is established or modified by the developer...4-22-13</p> | |

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| W 263 | <p>Continued From page 18 effective dates of implementation identified as August 10, 2012 through August 9, 2013.</p> <p>Additional review of the BSP on March 26, 2013, at 2:00 p.m., revealed a section of the BSP entitled "Staffing Supports." The BSP included: "[Client #3's name] does not require one-to-one supervision. He should be provided 24 hour staffing supervision."</p> <p>An associated consent form was also found in the record, dated August 9, 2012. Signature attestation was evident from Client #3's legal guardian providing consent for the BSP, dated August 8, 2012, which did not include consent for one-to-one supervision.</p> <p>In a follow-up interview with the QIDP on March 26, 2013, at 4:35 p.m., she stated that one-to-one supervision was implemented beginning in October 2012. At the time of the survey, the facility's specially constituted committee did not ensure written consent was obtained prior to implementation of one-to-one supervision when it was initiated in October 2012, three months after the latest BSP update.</p> | W 263 | | |
| W 295 | <p>483.450(d)(1)(i) PHYSICAL RESTRAINTS</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to clarify and ensure restraint procedures were integrated as part of a</p> | W 295 | | |

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| W 295 | <p>Continued From page 19 behavior support plan (BSP), for one of three clients in the sample (Client #3)</p> <p>The findings include:</p> <p>1. On March 25, 2013, at 6:05 p.m., Client #3 was observed at dinner. Client #3 had splints on both of his wrists as he ate. Concurrent interview with his one-on-one direct support staff (Staff #13) at the time revealed the splints were used for "contractures."</p> <p>Record review for Client #3 on March 26, 2013, commencing at 2:00 p.m., revealed a dermatology consult dated March 13, 2012. It documented "Lichen Simplex Chronicus of both dorsal hands - dry, rough, thickened from repetitive rubbing, scratching and biting. Recommendations - keep wrist guards in place as they help decrease his hand biting/rubbing."</p> <p>Additional documentation related to Client #3's biting behavior was evident in the monthly "Health Risk Management Care Plans" completed by nursing personnel from August 2012 through February 2013. In each month, it stated "Encourage wrist guards to reduce hand biting."</p> <p>Concurrent review of the behavior support plan (BSP) for Client #3 revealed a BSP with an effective date of August 9, 2012, revealed a "Behavior Support History" that included "[Client #3's name] has historically had an Axis 1 diagnosis of Obsessive Compulsive Disorder and Intermittent Explosive Disorder. He has received behavior support for several years for hand and wrist biting. Calluses have resulted on the back of his hand from these incidents and have led to</p> | W 295 | <p>W295</p> <p>Staff members #10 and #12 will be retained to ensure they understand that the wrist guards used by Client #3 prevent hand/wrists biting and are not in place because of contractures...5-1-13</p> <p>The RN will review the HMCP strategies with all staff to refresh all on the treatment needs of Client #3 and each person supported in the home...5-15-13</p> <p>The QIDP will be retained by the Administrator to ensure that there is a clear understanding on restraints and the associated policies (BRA and DDS). This training will be completed by...5-7-13</p> <p>The psychologist will be informed about the interaction on the stairs between Staff #18 and Client #3 to determine if any safety precautions need to be put in place when Client #3 is negotiating stairs but we are waiting for the written protocol by the physical therapist. Training for the staff was done by the physical therapist on 04.27.13 at the home...5-7-13</p> <p>If it is required, the protocol will be developed by psychology and staff will be trained by...5-15-13</p> |

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| W 295 | <p>Continued From page 20 consultations with dermatology. He was prescribed the use of wrist guards."</p> <p>Per review of the most recent physician order sheets in Client #3's record, dated February 26, 2013, there was no order specifically written for the wrist guards.</p> <p>In a follow-up interview with the qualified intellectual disabilities professional (QIDP, Staff #1), on March 26, 2013, at 3:25 p.m., to ascertain if there were any current physician orders for wrist guards, the QIDP verified there were none after conducting her own review. When the QIDP was asked how the wrist guards were to be used, given the comments provided by the dermatologist and monitored by nursing as being necessary due to biting behavior, she explained that since restraints were not used at the facility, this could not be part of the client's plan. The QIDP inferred that the Department on Disability Services (DDS) would not approve a plan if restraints were suggested. When she was asked if there was a plan outlining the application, release, the documentation necessary, as well as a plan for reduction of the use of wrist guards, the QIDP verified there were no such provisions in place.</p> <p>In follow-up interviews with three direct support staff on March 26, 2013, at 4:35 p.m., to ascertain their knowledge regarding the reason behind Client #3's wrist guards: Staff #10 and #12 stated wrist guards were used for contractures. Staff #18 stated they were used to prevent Client #3 from biting his hands.</p> <p>2. On March 26, 2013, at 8:40 a.m., Client #3 was</p> | W 295 | | | |

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| W 295 | <p>Continued From page 21</p> <p>observed standing at the top of the stairwell near his bedroom. Client #3's one-to-one direct support staff (Staff #10) asked another staff (Staff #18) to watch Client #3, while she retrieved additional clothing and adult incontinent briefs for him from another room. Client #3 was observed trying to walk down the stairs, but Staff #18 held onto his right shoulder, preventing the client's ability to walk down the stairs. Staff #10 returned shortly thereafter and observed them at the top of the stairs. Client #3 broke away from Staff #18's physical hold while striking and kicking at Staff #10. Client #3 then went downstairs.</p> <p>In a follow-up interview with the QIDP (Staff #1) on March 26, 2013, at 3:35 p.m., about the restraint used to prevent Client #3's egress earlier that day, the QIDP replied restraint was prohibited and, therefore was not incorporated in Client #3's BSP. She further stated that the facility used the DDS policy, dated August 1, 2011, entitled "Positive Behavior Restraint Support" as its authority regarding the development of behavior support plans. Under "6- Standards," it stated "The following are the standards by which DDS will evaluate compliance with this policy ... A ... BSP shall be developed in response to any of the following occurrences ... V- Use is made of any restrictive controls (i.e., any device, procedure, protocol or action that restricts, limits or otherwise negatively impacts a person's freedom of movement, control over his/her body, access to tangibles/intangibles normally available to individuals in this society; or privacy)." The policy did not prohibit the use of restrictive controls, but rather outlined the procedures that must be taken and followed whenever restrictive interventions are required as necessary for behavioral</p> | W 295 | | |

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| W 295 | Continued From page 22 | W 295 | | | |
| W 331 | amelioration. 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 observation, interview and record review, facility nursing staff failed to implement each client's seizure management plan as written, for one of three clients in the sample. (Client #2) The finding includes: On March 25, 2013, at approximately 9:00 a.m., Client #2 was observed wearing a soft helmet while ambulating from the living room to the dining room. He was observed wearing the helmet again while ambulating later on that day, at approximately 4:40 p.m. His day shift one-to-one direct support staff (Staff #11) stated Client #2 must wear the helmet while ambulating for safety, due to risk of seizures. According to Staff #11, the client routinely experienced one or two seizures per month, his most recent having occurred approximately one month prior to this survey. At 6:52 p.m., Client #2 was observed being administered Tegretol 300 milligram (mg), Keppra 500 mg and Lyrica 100 mg by the evening nurse (Staff #7). Staff #7 indicated the three aforementioned medications were prescribed for seizure management. On March 26, 2013, at 7:53 a.m., Client #2's nighttime one-to-one staff (Staff #12) was overheard informing the qualified intellectual | W 331 | W331 Out of range appropriate lab values will continue to be shared with the PCP and any other relevant clinical discipline within 24/48 hours of receipt and immediately if the levels suggest a immediate health concern for the person...5-5-13 (Example: Client #2 has a Neurology consult to the PCP noting specifically, "...More over I would leave his Carbamazepime at the levels between 17 and 19. I would not hold meds for this level purely based on the basis of his level. I believe this is the therapeutic range for him. I suspect he would not become clinically toxic unless he were well above 19, that is into the low 20's and if he became symptomatically toxic by being somnolent, clearly ataxic, vomiting, and so forth, then one would gently hold his medicines until his levels drifted into the upper teens and would then reestablish the medicine at that time...") This process will continue to be implemented by nursing staff. | | |

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| W 331 | <p>Continued From page 23</p> <p>disabilities professional (Staff #1) that the client had experienced a seizure overnight. At approximately 8:20 a.m., Client #2 was observed showing signs and symptoms of another seizure while in the dining room. The consulting registered nurse (Staff #4) advised staff by telephone to keep the client home from day program for monitoring.</p> <p>Per review of Client #2's neurology records on March 26, 2013, beginning at 10:40 a.m., it was verified that Client #2 had one or two seizures per month. Consultation forms documented neurology appointments on May 16, 2012, August 7, 2012 and February 13, 2013. There were documented lab reports (for Tegretol) in the client's record, dated August 8, 2012, December 6, 2012 and February 14, 2013. The current physician's order sheets (POS) for March 1, 2013 - March 31, 2013 included "monitor labs every 3 months."</p> <p>Additional review of Client #2's medical records revealed a Health Risk Management Care Plan (HRMCP), dated March 20, 2013 indicating "Tegretol levels can be therapeutic for <client's name> at levels that are noted to be toxic for other individuals. Tegretol levels can be elevated [16.5 - 19.5 micrograms per milliliter (mcg/ml) if asymptomatic and do not hold medication and greater than 20, 21 hold the medication. Clarify with neurologist... Nursing will provide information to the primary care physician (PCP) and neurologist as received."</p> <p>There was no evidence that facility nursing staff implemented the aforementioned procedure outlined in Client #2's seizure management plan,</p> | W 331 | | |

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| W 331 | Continued From page 24 as follows: The client's lab report for a blood sample drawn on December 6, 2012, reflected a Tegretol reading ">20 mcg/ml." [Note: The report did not provide a more specific reading; only that it was greater than 20.] Continued review of nursing notes and other documentation in the client's chart failed to show evidence that the neurologist or the PCP were notified timely of the test results showing Tegretol levels greater than 20 mcg/ml. The PCP had initialed the lab report on December 31, 2012 (3 weeks after the facility received the report by fax, on December 10, 2012). The first documented contact with the neurologist was February 13, 2013 (2 months after the labs). On March 27, 2013, beginning at 2:33 p.m., the consulting registered nurse (Staff #4) was interviewed by telephone to ascertain Client #2's seizure management protocol, including the reporting of higher-than-usual Tegretol lab values to the neurologist. She stated that the range of 16.5 - 19.5 mcg/ml Tegretol had been established by the neurologist and PCP back in 2008. The client was considered "asymptomatic" if he was experiencing one or two seizures per month, "his baseline." When asked if the ">20 mcg/ml" value (December 6, 2012) had been shared timely with the neurologist and/or PCP, she reviewed nursing and staffing notes on Therap (computerized, individual medical records maintained online) and stated she saw no evidence the neurologist or PCP had been notified timely for clarification. | W 331 | | | |
| W 368 | 483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure | W 368 | | | |

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| W 368 | <p>Continued From page 25 that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the licensed practical nurse failed to ensure that medications were administered on time, for three of three clients in the sample. (Clients #1, #2 and #3).</p> <p>The findings include:</p> <p>During the evening medication administration, the licensed practical nurse (LPN, Staff #7) failed to administer medications in accordance with physician's orders, as follows:</p> <p>1. On March 25, 2013, at approximately 7:00 p.m., Staff #7 stated that Client #1's "medications were going to be late." She administered Client #1's medications, at 7:17 p.m. His medications consisted of Topiramate, Trileptal, Oxcarbazepine, Levetiracetam, Keppra, Dilantin, Folic Acid, and Docusate.</p> <p>On March 25, 2013, at approximately 8:15 p.m., review of the client's medication administration record (MAR) and physician's order sheets (POS) dated March 1, 2013, revealed the aforementioned medications were prescribed for 6:00 p.m. administration.</p> <p>2. Continued observation, at 7:22 p.m., revealed Staff #7 administered Client #4's medications. The medications consisted of Simvastin, Desmopressin and Fiber Veg Lax. At 7:23 p.m., Client #4 asked Staff #7 for his eye drops as she</p> | W 368 | <p>W368</p> <p>BRA will retrain the medication administration nurses to ensure that timely feedback is provided if they are projected to be late for med passing. A discussion will be held with the PCP/designee for Specialty MDs to extend the times for passing meds to (i.e. 7am—between 6a and 8a) and if for</p> <p>another reason such as the individual is detained somewhere, nursing will obtain an order to provide meds when outside the documented times on the MARs (i.e. outside the new two hour window allowed). The RN will provide the training... 5-7-13</p> <p>The RN has already provided education and verbal reinforcement to the relevant LPNs.</p> <p>Additionally, the PCP and RNx2/LPNs will discuss the medication regimens of all of the individuals to include:</p> <p>1-identifying any medication that requires definitely fixed times such as diabetic meds so that they are taken timely in relation to meals, blood sugar testing, and meds, or other medications that require a very specific time structure due to blood levels.</p> <p>2-reviewing all meds to provide safety as to duplication, side effects, interactions, and reducing the quantity if possible and still obtain the outcomes desired</p> <p>3-in case of an emergency for nursing, staggering times will be an option and put in writing before the end of the day in which it occurs.</p> <p>4-BRA will maintain the integrity of the medication regimens for all of the individuals with the goal being that the individual achieves the desired outcome of the medication and the documentation of the time is accurate within the two hour window. 5-15-13</p> | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4829 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
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| W 368 | Continued From page 26 began to walk away. Staff #7 then indicated she would come back with his eye drops. At 7:49 p.m., the LPN applied Refresh Drops and Refresh Luci lube to both his eyes then administered Nasonex in each nostril. On March 25, 2013, at approximately 8:20 p.m., review of the client's medication administration record (MAR) and physician's order sheets (POS) dated March 1, 2013, revealed the aforementioned medications were prescribed for 6:00 p.m. administration. Interview with Staff #7 on March 25, 2013, at approximately 8:00 p.m., confirmed that Client #4's aforementioned medications were not administered timely. 3. Client #2 was observed being administered his medications on March 25, 2013, at 6:54 p.m. The medications consisted of Keppra, Hydroxyzine, Calcium, Lyrica, Tegretol and Polyethylene. On March 25, 2013, beginning at approximately 8:25 p.m., review of Client #2's POS showed the Polyethylene was prescribed for 6:00 a.m. administration. [Note: All other medications were prescribed for 6:00 p.m. administration.] The client's MAR, however, showed someone had changed the "am" to a "pm." | W 368 | BRA continues to maintain a strategy to train DSP supports to pass medications and plan to have a number of staff trained in each location by... 12-30-13 The error (am to pm) for Client #2's Polyethylene was corrected; an RN and the administrative support LPN will audit the MARs each month prior to distribution. Those MARS are placed into the books prior to the 1 st of each month and a copy sent to the QA/RN to review. The goal is always 100% accuracy for all medication involved documents. The 3 nurses involved with the initial review and checking have discussed the situation and will also solicit input from the med pass nurses as they use and review the newly placed MARS 5-15-13 | | |
| W 371 | 483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure | W 371 | | | |

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| W 371 | Continued From page 27 that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews, and the review of records, the facility failed to afford each client the opportunity to participate with self medication to the extent of his ability, for one of five clients residing in the facility. (Client #4) The finding includes: On March 25, 2013, at approximately 5:00 p.m., Client #4 ate his snack independently with a regular utensil and cup then cleared the table. At approximately 7:00 p.m., Client #4 was observed playing a video game with the use of a hand held device. Observation of the medication administration on March 25, 2013, beginning at 5:43 p.m., revealed the licensed practical nurse (LPN, Staff #7) prepared Client #4's medications. The nurse punched and measured Client #4's medications into a medication cup. Continued observation at 7:22 p.m., revealed Staff #7 handed the client his medications. The medications consisted of Simvastin and Desmopressin. She then handed the client a cup of water mixed with Fiber Veg Lax. At 7:23 p.m., Client #4 asked Staff #7 for his eye drops as she began to walk away. Staff #7 then indicated she would come back with his eye drops. At 7:49 p.m., Staff #7 applied Refresh Drops and Refresh Lucri lube to both his eyes then administered Nasonex in each nostril. | W 371 | W371 A task program surrounding times that medications are passed will be implemented for Client #4 that reflects his existing strengths and capabilities and his potential for accomplishing the tasks...5-10-13 The program will be implemented beginning...5-15-13 The RN has reviewed the self medication assessments for each person supported and the self medication programs to determine if there are any improvements or new individuals that may be capable of participating. All of the individuals currently at BRA remain able to only participate in the "TASKS" surrounding self-medication, not the clinical/cognitive process of self-medication. The assessments will be completed in writing, sent to the PCP and placed in the record. The current assessments concludes that none of the individuals are capable of "self-medication" as of 5/2012. The IPP will reflect the individuals' abilities to participate in the individually identified tasks and the DSPs will document that as part of their program and data collection on the programs. ...5-30-13 | |
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| W 371 | Continued From page 28 On March 25, 2013, at approximately 8:05 p.m., Staff #7 stated that Client #4 was capable of being trained to administer his Nasonex and participate in a self medication administration program. On March 27, 2013, at approximately 5:00 p.m., review of Client #4's Self Administration of Medication Assessment Form, dated May 8, 2012, revealed the client "is not recommended for the self administration of medication training program at this time." Further review revealed the client was not able to name the medications he received. | W 371 | | |
| W 381 | The facility failed to afford Client #4 the opportunity to participate with self medication to the extent of his ability 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the licensed practical nurse (LPN) failed to store liquid Lactulose under proper conditions of security, for one of the five clients residing in the facility. (Clients #5) The finding includes: On March 25, 2013, at 6:39 p.m., the LPN (Staff #7) was observed to leave Client #5's liquid Lactulose in the dining room while she went into | W 381 | W381 The RN provided reinforcing feedback to the LPN about ensuring medications are secure at all times...4-1-13 The RN will provide formal follow up training by...5-7-13 The QIDP and home manager will observe medication passing during their routinely weekly monitoring to ensure that the prescribed protocols are followed and will report any issues they observe to the RN for immediate follow up...beginning 5/13 | |

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| W 381 | Continued From page 29 Client #1's bedroom to administer his medications. During this time, Client #4 and facility staff were in close proximity to the medication, which had been left unattended. | W 381 | | | |
| W 436 | When interviewed on March 25, 2013, at approximately 8:00 p.m., Staff #7 acknowledged that the medication had been left unsecured. 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish a system to ensure each client's wheelchair was maintained in good repair, for one of one client in the sample that used a wheelchair for mobility. (Client #1) The finding includes: On March 25, 2013, at approximately 9:00 a.m., a pillow was observed under Client #1's arm as he sat in his wheelchair. Further observation revealed the cable located on the back of the wheelchair was broken. Interview with the direct support staff (Staff #9), at approximately 9:05 a.m., confirmed the cable was broken but the wheelchair was safe and secure. Staff #9 said the cable was used for repositioning the chair. He then demonstrated that he could still reposition | W 436 | W436 A new vendor has been identified that will complete the necessary repairs to the wheelchair of Client #1 by...5-30-13 All adaptive equipment issues are audited monthly with the Senior QIDP serving as the point person for collecting the data and submitting a summary report to DDS. Effective immediately, the Senior QIDP will conduct home-by-home site audits to determine the status of each piece of adaptive equipment as opposed to calling and relying on the feedback of home managers and staff on duty. Issues discovered in the site audits will be reported to the administrator, RN and relevant clinicians for follow up...5-1-13 Additionally, adaptive equipment issues will be discussed home-by-home and in a person-specific manner during the weekly management team meetings...5-1-13 | | |

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| W 436 | Continued From page 30 the wheelchair manually, using a lever underneath. On March 26, 2013, at 3:55 p.m., review of Client #1's annual physical therapy evaluation dated July 6, 2012, revealed a recommendation that stated "follow up with wheelchair vendor. Can pelvic and trunk laterals be used to improve his alignment? Install a back support to support his side bend trunk. Can the headrest be aligned to support his head? New seat cushion." Review of a physical therapy note dated March 22, 2013, revealed "the headrest needs to be adjusted." In bold letters, the physical therapist wrote "Contact wheelchair vendor for repairs. He would benefit from a new seating system to support his deformities." On March 27, 2013, at 10:15 a.m., interview with the qualified intellectual disabilities professional (Staff #1) and the house manager (Staff #2) revealed a wheelchair vendor had been contacted in August 2012. The owner of the company, however, had passed away. They acknowledged that no follow-up actions had been taken to address the recommendations made by the PT on July 6, 2012 (8 months earlier). Staff #2 then added she would contact a new wheelchair vendor "today." | W 436 | | | |
| W 454 | 483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure infection | W 454 | | | |

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| W 454 | <p>Continued From page 31</p> <p>control practices were enforced when recreational materials were presented, for one three clients in the sample. (Client #3)</p> <p>The findings include:</p> <p>1. On March 25, 2013, Client #3 and his assigned one-to-one direct support staff (Staff #13) were observed in the facility, beginning at 6:00 p.m. Prior to the dinner meal being served, Client #3 was engaged in a ball toss activity in which he would touch the ball, roll the ball on the floor and sometimes place the ball to his face. Additionally, Client #3 was offered a popper top spinning toy that he would sometimes lick. During these observations, Staff #13 did not intervene in any manner with Client #3 to get him to keep the items away from his face, lips, or tongue. Prior to the meal being served, Client #3 was not encouraged to wash his hands.</p> <p>2. On March 26, 2013, beginning at 6:55 a.m., observations of Client #3 and his assigned one-to-one direct support staff (Staff #17) revealed the following:</p> <p>6:55 a.m. - Client #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>7:09 a.m. - Client #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>7:25 a.m. - Client #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> | W 454 | <p>W454</p> <p>Staff will be retrained on infection control by...5-7-13 Additionally, the QIDP will discuss the issue of Client #3 licking the ball or balls with the licensed psychologist and ask the psychologist to assist in developing strategies that staff will be trained to use that allow Client #3 to enjoy playing with balls while preventing the licking behavior. The psychologist will be contacted and the strategies will be developed by...5-10-13 Staff will be trained and the strategies will be implemented by...5-15-13</p> <p>The QIDP and Home Manager will monitor implementation of the prescribed strategies (once developed and staff is trained) during routine observations of active treatment weekly...6-1-13</p> | | |

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| W 454 | <p>Continued From page 32</p> <p>8:00 a.m. - Client #3 was again observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>In an interview with the qualified intellectual disabilities professional (QIDP, Staff #1) on March 26, 2013, at 4:35 p.m., the QIDP was asked if facility staff had been trained in matters of infection control. The QIDP stated that the issue of cleaning training materials had been discussed with all staff on a routine basis. [Note: On March 27, 2013, review of staff in-service training records, beginning at 12:30 p.m., failed to show evidence of training on infection control. The QIDP and the house manager (Staff #2) looked for documentation of said training but at approximately 1:15 p.m., they acknowledged that there were no records available for verification.]</p> | W 454 | | |
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