

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

PRINTED: 12/31/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2009
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from 12/8/2009 through 12/10/2009. The survey was initiated utilizing the fundamental survey process. However, due to the problems observed during the medication administration and information garnered from interviews with the nursing staff regarding the health and well-being of the clients, the survey was extended under the conditions of participation in Health Care Services.</p> <p>A random sampling of three clients was selected from a resident population of two women and four men with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the client and administrative records, including the incident reports.</p> <p>The resultant findings revealed the facility was out of compliance with the condition of participation in the areas of Client Protections and Health Care Services.</p>	W 000	<p><i>Received 1/20/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 122	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to ensure client privacy [Cross reference W130]; failed to conduct investigations into all injuries of unknown origin [Cross reference W 154]; failed to implement corrective measures in cases where violations have been verified [Cross reference W157]; failed to ensure staff was</p>	W 122		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Arthur Moore* TITLE *Director of Residential Services* (X8) DATE *1/14/10*

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 122	Continued From page 1 properly trained to implement and administer a client's medication regimen, repositioning regimen, and fluid texture requirements [Cross reference W192]; and failed to demonstrate competency in implementing a client's Behavior Support Plan (BSP) [Cross reference W193]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety. [Cross reference W318]	W 122			
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure client privacy in times of personal treatment for one of six clients residing in the facility. [Client #2] The finding includes: On the evening of 12/8/2009 at approximately 8:35 p.m., this surveyor accompanied the evening medication nurse to Client #1's bedroom in effort of observing her administer his medications. Upon entering the bedroom, Client #2 was observed sitting naked in a shower chair in the middle of the room. Both doors to the room were completely ajar and there was no additional staff in the bedroom at the moment of our entrance. Within a minute, one of the facility's staff entered the room and began to organize Client #2's bathing supplies in preparation for his shower.	W 130	The MTS management team has met and has developed a plan of action to address the deficiencies cited under W122, its associated tags and those cited throughout the deficiency report. Implementation of the plan is in progress (See also: the responses for W130, W154, W192 and W193).		

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W 130	Continued From page 2 The staff then took the bathing supplies to the bathroom (directly across the hall) and re-entered the bedroom. While the nurse continued to administer Client #1 his medications, the attending staff took a bath towel and placed it across Client #2 ' s lap and wheeled him out of the bedroom and across the hall into the bathroom. The medication nurse did not address Client #2 being naked when she first entered the room or when he sat naked in the shower chair during the medication pass. It was not clear how long Client #2 sat in the room without any clothing in his shower chair prior to our entrance into the bedroom. Interview with the facility ' s qualified mental retardation professional (QMRP) on 12/8/2009 at approximately 8:40 p.m. revealed she was not certain why the staff allowed Client #2 to sit naked in his room or why the nurse did not ensure Client #1 ' s privacy during the medication pass. The QMRP stated the staff should have undressed him in the bathroom as opposed to his bedroom. The facility failed to ensure client privacy during times of personal care as required by this section.	W 130	W130 All staff will be retrained on privacy and dignity issues. Special attention will be given to privacy during bathing and personal care. This training will be completed by... 1-14-10. In addition, the QMRP and facility manager during separate visits will monitor the implementation of active treatment and supported routines at minimum two times weekly each to insure that staff consistently respect the privacy of the individuals they support... 1-14-10. The privacy violations and other actions by the Licensed Practical Nurse (LPN) resulted in a termination action by MTS. This LPN was replaced by another experienced, trained LPN who received training on privacy issues and all other aspects of MTS' medication administration policy... 1-14-10. All medication passing nursing personnel was also re-trained on appropriate medication administration with specific attention given to the concerns outlined in the survey document's relevant tags... 1-14-10. Additionally, MTS provides a guideline for medication administration that is stored in the front of each MAR book to be reviewed by the LPN prior to beginning the medication pass. The DON and RN reviewed the guide with the medication nurses during the re-training process... 1-14-10.		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure injuries of unknown origin were thoroughly investigated as required by this section for two of six clients residing in the facility. [Clients #3 and #4]	W 154			

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W 154	<p>Continued From page 3</p> <p>The findings include:</p> <p>Review of the unusual incident reports (UIR) on 12/8/2009 at approximately 10:40 a.m. revealed the following unusual incidents:</p> <p>1. On 11/9/2009, Client #3 was taken to the ER for what was later diagnosed as being a "sprained" (left) wrist. The UIR detailed, "staff reported to the nurse that she noticed [Client #2] was having difficulty using his [left] hand ... upon assessment, I found out that the individual could not hold his cup or his spoon to eat his food. When I asked him to squeeze my hand, he hardly did so." The primary care physician, the nurse coordinator and the nurse supervisor were notified and Client #3 was taken to a local hospital for emergent care (ER).</p> <p>On 12/10/2009 at approximately 5:57 p.m., the QMRP provided additional information about the injury. According to the QMRP, the facility's staff repositioned him in his bed incorrectly with his left hand underneath him and slightly to his back. The QMRP indicated the poor positioning may have been the cause of Client #3's sprained wrist.</p> <p>2. On 11/24/2009, Client #4 was taken to the ER for having bruises and discolorations on his left wrist. The UIR detailed discolorations were observed on Client #4's left wrist during his afternoon bath. According to the report, the qualified mental retardation professional (QMRP), the house manager (HM) and the evening medication nurse were informed of the discolorations.</p>	W 154	<p>W154</p> <p>1. Although the QMRP did provide the surveyor with the explanation described in the language of W154 (i.e. that Client #3's "wrist sprain" was due to him being repositioned improperly by a staff member), further questioning by the MTS QA Consultant revealed; (a) the QMRP did not observe an improper repositioning herself; (2) the staff member that speculated this (improper repositioning) had occurred did not see that happen herself nor did she identify any specific staff member who had committed the act; (3) in obtaining statements from the remaining staff members, no staff member stated that they observed an inappropriate repositioning occur.</p> <p>Additionally, the ER report confirmed that there was no fracture and indicated that there was <u>possibly a sprain</u>. Follow up with orthopedic services was completed and the DON was provided with verbal feedback indicating that it was unlikely there was a sprain to the wrist. Client #3's wrist has contractures. Both the assumption that staff repositioned Client #3 incorrectly and the assumption that there was an actual wrist sprain are questionable. Client #3 was observed to have his arm somewhat under his body in the arm of the morning the wrist issue was noticed but both the DON and Lead RN pointed out he is perfectly capable of repositioning himself in that manner.</p> <p>The QMRP failed to provide factual feedback when responding to the surveyor's question on this subject and instead, provided speculation without concrete evidence. The Executive Director will re-train the QMRP on providing fact-based feedback... 1-14-10.</p> <p>Additionally, the QMRP failed to insure that a timely investigation was conducted to determine if there was an injury of unknown origin and if so, what caused it. The Executive Director will address this issue in the planned training session. The IMC will participate in the planned training session... 1-14-10.</p>		

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W 154	Continued From page 4 Further record review and interview with the facility ' s QMRP on 12/10/2009 at approximately 4:55 p.m. revealed there were no investigations on file at the time of survey for these injury reports.	W 154	2. The QMRP failed to insure that a timely investigation was conducted to determine if there was an injury of unknown origin for Client #4. The Executive Director will address this issue during the planned training session with the QMRP...1-14-10.	
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that corrective measures were put in place for incidents resulting in the injury or decline of a client ' s health as required by this section for one of three sampled clients. [Client #3] The findings include: Interview with the facility ' s qualified mental retardation professional (QMRP) on 12/10/2009 at approximately 5:55 p.m. revealed the following incident was verified as having taken place and that the resulting findings were accurate: On 11/9/2009, Client #3 was taken to the ER for what was later diagnosed as being a " sprained " (left) wrist. On the same day at approximately 5:57 p.m., the QMRP provided additional information about the injury Client #3 sustained on 11/9/2009. According to the QMRP, the facility ' s staff repositioned him in his bed incorrectly with his left hand underneath him and slightly to his back. The QMRP indicated the poor positioning may	W 157	W157 All staff will be retrained by the PT on repositioning Client #3...1-14-10. All new staff will be trained within the first week of hire (by nursing)...1-14-10. Training will be repeated at minimum every 6 months by the PT and within 5 days of any changes that are made in the protocol (and before a modified protocol is formally implemented)...1-14-10.	

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W 157	Continued From page 5 have been the cause of Client #3 ' s sprained wrist.	W 157		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for six of six of the clients residing in the facility. [Clients #1, #2, #3, #4, #5, and #6] The finding includes: 1. The QMRP failed to ensure staff received effective training to implement repositioning measures and to provide fluids in a form consistent with the developmental needs of the clients. [See W189] 2. The QMRP failed to ensure staff was properly trained to implement and administer a client ' s medication regimen. [See W192]	W 159	W159 The issues cited under W159 have been addressed as evidenced by the responses for W189, W192, W322, W331 and W474.	

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W 159	Continued From page 6 3. The QMRP failed to coordinate services to ensure instructions were given and disseminated regarding the use of Client #3 's hand splint. [See W322.3] 4. The QMRP failed to ensure the coordination of services to ensure a re-positioning program was implemented consistently to address Client #2 's decubitus ulcers. [See W331.2] 5. The QMRP failed to implement measures to ensure all staff was effectively trained to implement clients ' fluid texture requirements. [See W474]	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff received effective training to implement repositioning measures and to provide fluids in a form consistent with the developmental needs of a client for two of three sampled clients. [Clients #2 and #3] The findings include: 1. Staff interview and record review on 12/10/2009 at approximately 5:20 p.m. revealed, there was no evidence that all staff received training to properly implement Client #3 's repositioning plan. The records reflect, five out of fifteen staff failed to receive training on how to	W 189	W189 1. Repositioning training will be implemented by...1-14-10. 2. Staff will be re-trained on the fluid texture issue for Clients #2 and #3. Speech pathology will conduct the training...1-14-10.	

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W 189	Continued From page 7 properly implement Client #3 ' s repositioning treatment requirements as recommended by either the Physical Therapist (PT) or the Wound Care Specialist. [Staff #1, #3, #5, #10, #13] [Cross Reference W331]	W 189		
W 192	2. Staff interview and record review on 12/10/2009 at approximately 5:27 p.m. revealed, there was no evidence that all staff received training to properly implement Client #2 and Client #3 ' s fluid texture requirements over the past certification year. The records reflect, eight out of fifteen staff currently employed failed to receive training on how to properly implement these clients ' fluid texture requirements as prescribed by their primary care physician. [Staff #1, #3, #5, #6, #8, #9, #10 and #12] [Cross Reference W331] 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was properly trained to implement and administer a client ' s medication regimen, repositioning regimen, and fluid texture requirements for five of six clients residing in the facility. [Clients #1, #2, #3, #4 and #5] The finding includes: 1. During the evening medication administration on 12/8/2009 between the approximate times of 6:30 p.m. and 9:00 p.m., the attending licensed practical nurse (LPN) was observed performing	W 192	W192 1. The medication passing LPN in question has been terminated. The new LPN has been trained to insure proper procedures in passing medications... 1-14-10. All of the medication nurses have been re-trained... 1-14-10. Each MAR book has a protocol guide for medication administration that is to be reviewed prior to passing medications. Nurses have been re-trained on the use of the guide... 1-14-10. 2. Repositioning training will be completed... 1-14-10. 3. Fluid texture training by the speech pathologist will occur by... 1-14-10.	

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W 192	Continued From page 8 several procedural errors. She was observed not ensuring privacy when administering medications, not ensuring proper hygiene methods when preparing medications, not ensuring proper fluid textures when administering medications, failing to prevent potential cross contamination of medications between clients and walking away and leaving her medications unlocked and unattended. The facility failed to ensure its medical staff was properly trained to ensure privacy during the administration of medications; how to ensure hygiene methods while administer medications; establishing proper fluid textures; preventing potential cross contamination of medications; and securing medications during medication administrations. [Cross Reference W331 and W382] 2. Interview with the facility 's qualified mental retardation professional (QMRP) and record review on 12/10/2009 at approximately 5:20 p.m. revealed, there was no evidence that all staff received training to properly implement Client #3 's repositioning plan. [Cross Reference W189 and W331] 3. Interview with the facility 's qualified mental retardation professional (QMRP) and record review on 12/10/2009 at approximately 5:27 p.m. revealed, there was no evidence that all staff received training to properly implement Client #2 and Client #3 's fluid texture requirements. [Cross Reference W189, W331 and W474]	W 192		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions	W 193		

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W 193	<p>Continued From page 9 to manage the inappropriate behavior of clients.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility ' s staff failed to properly implement a client ' s behavioral interventions as outlined in his Individual Program Plan for one of three sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Observation on the evening on 12/8/2009 between the approximate times of 4:00 p.m. and 6:30 p.m. revealed Client #2 was observed engaging in several episodes of kicking, screaming loudly, and flailing of his arms while sitting in the living room with his house mates.</p> <p>At approximately 4:10 p.m., Client #2 was observed screaming loudly as he sat in his wheelchair. None of the facility ' s staff walked over to address his vocalizations. By approximately 5:00 p.m., he had two additional episodes of screaming loudly, but on the second occasion he was kicking and flailing his arms during the process. Around 6:00 p.m., the staff was observed holding his arm while implementing a range of motion exercise. Between the sessions, he began to kick with more force, scream and wave his arms.</p> <p>Record review on 12/9/2009 at approximately 10:00 a.m. revealed Client #2 ' s Behavioral Management Plan dated 6/20/2009 recommended the following interventions for his " Kicking and Screaming " ... " Verbally redirect [him] to his room with supervision if vocalizations are very loud. Provide music and gently talk to</p>	W 193	<p>W193</p> <p>Staff will be re-trained on proper implementation of Client #2's BSP on... 1-14-10. Psychology will conduct the training. Additionally, the QMRP and facility manager separately will observe active treatment implementation and daily supported routines at minimum twice weekly to insure the BSP mandates are followed as needed. Staff failing to do so will receive on the spot training on proper implementation of the strategies and that training will be documented by the QMRP or facility Manager... 1-14-10.</p>	

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W 193	Continued From page 10 him. Give him sensory materials to hold. Change your location around him if the yelling persists. Tell him what activity you are doing. Talk softly. Provide materials he can see, smell, hear or touch. Place soft objects in his hands. Redirect conversation if he begins to yell. Wait for a break in the yelling. If the yelling persists redirect him. Reduce the stimulation around him except for soft music. " Interview with the facility 's qualified mental retardation professional (QMRP) on 12/9/2009 at approximately 3:30 p.m. revealed the facility 's staff did not redirect him to his room; did not provide any music to him at the time of the incidents because the television was on instead; did not provide him any materials he could see, smell, hear or touch; did not place any soft objects in his hands; nor were they observed making attempts at " reducing the stimulation around him " as outlined in his plan. The facility 's staff failed to demonstrate the ability to properly manage Client #2 's behavioral outbursts as outlined in his behavioral management plan and as required by this section.	W 193			
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 observation, interviews, and record reviews, the facility failed to provide preventive and general health care services to meet the needs of the clients [Cross reference to W322]; failed to establish systems to provide health care	W 318			

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W 318	Continued From page 11 monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Cross reference to W331]; failed to ensure that medications were administered in accordance to physician's orders. [Cross reference to W368]; failed to ensure all drugs, including those that are self-administered, are administered without error [Cross reference W369]; and failed to ensure the security of medications during medication administrations [Cross reference W382].	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care 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's medical services failed to ensure the monitoring and oversight of client ' s health and safety needs for two of three sampled clients. [Clients #3 and #4] The finding includes: 1. The facility failed to ensure nursing staff were properly trained to administer medications. [See W331] 2. The facility ' s medical staff failed to ensure all medications were administered in accordance with the Physician ' s Orders. [Client #4][See W369]	W 322	W318 The concerns outlined in W318 have been addressed by the MTS responses and action plan as evidenced by the responses for W322, W331, W368, W369 and W382.	

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W 322	Continued From page 12 3. Observation on 12/8/2009 at approximately 4:15 p.m. revealed, Client #3 was wearing a hand splint on his left hand. Record review on 12/9/2009 at approximately 2:20 p.m. revealed, Client #3 ' s Physician ' s Orders dated 12/1/2009 lists the diagnosis of Osteoporosis. Further record review revealed Client #3 Physical Therapy assessment dated 9/15/2009 detailed the following diagnosis, " [Client #3] has been diagnosed with... osteoporosis, degenerative joint disease " . In addition, an incident report dated 11/19/2009 revealed this client was taken to the ER and was later discharged with the diagnosis of having a sprained wrist. Interview with the facility ' s registered nurse (RN) and the qualified mental retardation professional (QMRP) on 12/10/2009 at approximately 5:00 P.M revealed the client was wearing the hand splint because he had sprained his wrist. Further interview with the QMRP revealed the facility ' s staff repositioned him in his bed incorrectly with his left hand left underneath him and slightly to his back. According to the QMRP, this was where she believed Client #3 sprained his wrist. Additional record review and Interview with the facility ' s registered nurse and the QMRP on 12/10/2009 at approximately 5:22 p.m. revealed there was no written evidence on file to substantiate a course of treatment was identified to address the use of the hand splint, the overall care of the client ' s sprained wrist, or that the primary care physician was involved in the treatment process.	W 322	W322 1. See responses for W331 2. See responses for W369. 3. As indicated by the surveyor, the hand splint provided by the hospital after the ER visit for Client #3 was put on and used without receiving feedback from the attending physician at the hospital or from the primary care physician. MFS will insure in the future that no such piece of equipment is used without first obtaining feedback from the prescribing specialist or the PCP has to why the equipment is being used and specifically how to use it. The Executive Director will review this issue with the DON and the Lead RN in a formal training session to be conducted by... 1-14-10.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing	W 331		

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W 331	<p>Continued From page 13 services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's nursing staff failed to properly implement and administer a client's medication regimen for five of six clients residing in the facility. [Clients #1, #2, #3, #4 and #5]</p> <p>The finding includes:</p> <p>1. During the evening medication administration on 12/8/2009 between the approximate times of 6:30 p.m. and 9:00 p.m., the following procedural errors / deficient practices were observed during the administration of the evening medications:</p> <p>a. The licensed practical nurse (LPN) served Client #4's water in a regular consistency during the medication administration. Client #4's 11/2009 Physician's Orders prescribed "ground [food] ... thick liquids" as part of his altered texture diet.</p> <p>b. Six of Client #4's medications (pills) were taken out of the small container of applesauce when the nurse was advised he was on an altered texture diet. During her attempt to correct the error, the licensed practical nurse (LPN) took the pills out of the applesauce with her bare hands and placed them in a wooden grinding bowl to be crushed. After crushing the medications, she scraped out the excess and put them back in the same small container of applesauce and administered it to Client #4.</p> <p>c. Client #4's Prolixin (for Schizophrenia) was over poured to approximately 10mls in a small</p>	W 331	<p>W331</p> <p>1a. the nurse that provided water at regular consistency for Client #4 was terminated... 1-14-10.</p> <p>1b. same as 1a above; additionally, nurses were re-trained on this subject... 1-14-10. The grinding bowl method of crushing medications has been replaced by the "Silent Night Pill Crusher". The DON and Lead RN will develop a protocol for using the pill crusher and train nurses on the protocol... 1-14-10.</p> <p>1c. a new measuring tool will be obtained that is more precise and exact in measuring liquid medications. Nurses will be trained on the use of the new tool... 1-14-10.</p>	

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W 331	<p>Continued From page 14</p> <p>plastic measuring cup. Prior to administering the medication, the licensed practical nurse (LPN) was redirected to check the prescribed dosage. Upon further review, she confirmed the dosage should have been 4mls and attempted to correct the error. During her attempt at correcting the error, she poured out the excess Prolixin into another small measuring cup and tried to measure out 4mls in the process. The graduated measuring marks on the cup read 2.5mls, 5mls, and then 10mls. There was no 2ml or 4ml marker on the measuring cup.</p> <p>During her second attempt at properly measuring out 4mls, she conferred with the Supervisory Registered nurse who was on site, and decided to use a small syringe to pull 4mls of the medication out of the small measuring cup. She pulled 2mls of Prolixin and then another 2mls and administered it to the client.</p> <p>d. Clients ' #2, #3, #4 and #5 were served their medications in the hallway in front of the staff ' s office. They were not afforded any privacy during the administration of their medications. Their housemates were sitting in the living room in clear view of the hallway in front of the staff ' s office.</p> <p>e. Client #3 ' s water was served in a regular consistency during the medication administration. Client #3 ' s 11/2009 Meal Time Feeding Protocol prescribed " nectar to pudding " thick consistency for his liquids.</p> <p>f. Client #2 ' s pills were also crushed in the small wooden grinding bowl after Client #5 ' s medications were crushed and administered. The licensed practical nurse (LPN) indicated she cleaned out the grinding bowl by wiping it clean</p>	W 331	<p>1d. Privacy in administering medications will be covered in the nurses training on appropriate medication administration... 1-14-10. Additionally, the MTS guide placed in every MAR also addresses the issue... 1-14-10.</p> <p>1e. the speech pathologist will review each liquid thickening regimen to insure that it is appropriate for each person and has clear instructions to follow. Instructions will be made clearer as needed and the speech pathologist will retrain staff... 1-14-10.</p> <p>It is important to note that although there are specifics amounts indicated for "honey consistency" and "nectar consistency", these amounts are estimates. The DON and Lead RN point out that it may take a little more to achieve the required texture. In addition, the longer a mix sits, the thicker it gets. This will be addressed in the upcoming training for staff and medication passing nurses... 1-14-10.</p> <p>1f. See 1b above.</p>	

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W331	<p>Continued From page 15</p> <p>with a napkin before crushing Client #2 ' s medications in it. The wooden grinding bowl was never observed to be washed with water or any other cleaning solution prior to the LPN using it to crush a second set of medications.</p> <p>g. Client #2 was served his water at a " nectar " consistency during the med pass. The Supervisory Registered nurse who was onsite during the medication administration confirmed that the water was served at a " nectar " consistency. Note: the nurse also had a difficult time figuring out the amount of scoops required to get the water to be at a " honey " consistency as prescribed on his 12/1/2009 Physician ' s Order sheets (POS).</p> <p>h. The nurse left the medication ' s filing cabinet unlocked and open when she walked out of the staff ' s office to go " wash " the wooden grinding bowl after serving Client #2 his medications.</p> <p>i. The nurse left the medication ' s filing cabinet unlocked and open a second time when she walked to Client #1 ' s bedroom to administer his evening medications.</p> <p>j. Client #1 ' s evening dosage of Miralax (17gms into 8oz of water) was not available to be administered. The LPN was not sure if she had ordered the medication as it had run out the evening before. The Supervisory Registered nurse who was on site contacted the primary care physician (PCP) and the local pharmacy to initiate the process of securing the medication.</p> <p>Interview with the facility ' s supervisory registered nurse (SRN), registered nurse (RN), the qualified mental retardation professional (QMRP) and</p>	W331	<p>lg. See 1e above.</p> <p>lh. and li. Securing the medications at all times will be covered in the medication nurse training to be conducted by...1-14-10. Additionally, the MAR guide provided covers this concern and will be reviewed in the nursing training session as well...1-14-10.</p>		

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W 331	<p>Continued From page 16</p> <p>house manager (HM) on 12/8/2009 at approximately 9:08 p.m. revealed they would ensure that all nursing staff be aware of these deficient practices and also ensure all nursing staff would be retrained to address these potential problems. [Cross reference W368, W369, W382, and W474]</p> <p>2. Observation on 12/8/2009 from approximately 4:00 p.m. to 7:30 p.m. revealed, Client #2 was allowed to sit in his wheel chair without any repositioning. At approximately 4:00 p.m., Client #2 was observed sitting in his wheelchair in the living room with his housemates.</p> <p>At approximately 4:20 p.m., he was observed eating snack at the table with his peers. Between 4:20 p.m. and approximately 6:15 p.m., he was observed sitting in the living room waiting for dinner. Between 6:15 p.m. and approximately 6:40 p.m. he was observed sitting at the dinner table eating his meal. After dinner, he sat in the living room with his peers until approximately 7:30 p.m. when he received his evening medications. After his medications, he was wheeled back out into the milieu.</p> <p>Interview with the facility 's registered nurse (RN), the qualified mental retardation professional (QMRP) and record review on 12/10/2009 at approximately 1:40 p.m. revealed, Client #3 's 9/14/2009 Wound Care Assessment detailed he had a stage 4 right Ischial pressure sore and a Stage 2 left Ischial pressure sore. This assessment revealed the attending Physician prescribed the following treatment measures:</p> <p>a. Keep weight off [wound].</p>	W 331	<p>1j. the medication was ordered and received in one day. One dose was missed by Client #1. This was reported to the PCP and no ill-effects were noted...1-14-10.</p> <p>The medication was not ordered in a timely manner because the medication nurses failed to alert the Lead RN, DON or the MTS nursing office when it was in low quantity. To insure there are no repeat episodes:</p> <ul style="list-style-type: none"> • The medication passing nursing will be re-trained to alert the Lead RN, DON and/or the nursing office when a medication is in low supply (i.e. 2 or less days of doses in hand) so that reordering can occur...1-14-10. • The Lead RN will conduct periodic cabinet checks to insure that medications are in adequate supply and these periodic checks will occur no less than monthly...1-14-10. • Nursing Office Administrative Support LPNs will conduct similar checks no less than twice monthly to insure the same...1-14-10. <p>2. PT will retrain staff on Repositioning Client #2 and on the repositioning protocol during the planned training on... 1-14-10.</p> <p>The QMRP and facility manager will monitor routine implementation during weekly active treatment observations...1-14-10. Staff will receive on-the-spot training during observations when the protocol is not being followed... 1-14-10.</p> <p>The HMCP will address the repositioning issue as a part of addressing the pressure sore consideration generally. Staff will be trained on the care plan mandates...1-14-10.</p>	

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W 331	Continued From page 17 b. Seat lifts or shift weight in chair every 15 minutes. c. Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB elevation to 30 degrees in bed. Further review on the same date at approximately 1:50 p.m. revealed, Client #3 's Physical Therapy Assessment dated 9/15/2009 recommended the following interventions: a. Limit sitting in the wheelchair to meals and one hour after meals. b. Consider changing his position every hour during the day. The facility 's nursing staff failed to ensure Client #3 's "sitting " be limited to meals and one hour after meals; failed to provide repositioning each hour; failed to implement seat lifts or shift weight in chair every 15 minutes; and failed to " avoid direct pressure over wound site " as recommended by the Physical Therapist and the wound care specialist respectively. In addition, there was no evidence that an effective repositioning program was in place to address this client ' s pressure sores.	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 staff interview and record review, the	W 368			

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W 368	Continued From page 18 facility failed to ensure that medications were given in compliance with the physician's orders for one of two clients in the sample. [Client #1] The finding includes: During the evening medication administration on 12/8/2009 at approximately 7:50 p.m., Client #1 ' s evening dosage of Miralax (17gms into 8oz of water) was not available to be administered. The licensed practical nurse (LPN) was not sure if she had ordered the medication and also indicated it had " run out " the evening before. The supervisory registered nurse (SRN) who was on site contacted the primary care physician (PCP) and the local pharmacy to initiate the process of securing the medication. Record review on the same night at approximately 8:30 p.m. revealed Client #1 ' s physician's orders (POS) dated 12/1/2009, documented " Miralax 2 Tablespoon full dissolved in liquid by mouth every evening for constipation ". In an interview with the LPN and the SRN on the same night at approximately 8:35 p.m., it was acknowledged that the medication was not available in the facility and there was no written evidence to support that the medication had been re-ordered. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders.	W 368	W368 The medication was not ordered in a timely manner because the medication nurses failed to alert the Lead RN, DON or the MTS nursing office when it was in low quantity. To insure there are no repeat episodes: <ul style="list-style-type: none"> The medication passing nursing will be re-trained to alert the Lead RN, DON and/or the nursing office when a medication is in low supply (i.e. 2 or less days of doses in hand) so that reordering can occur... 1-14-10. The Lead RN will conduct periodic cabinet checks to insure that medications are in adequate supply and these periodic checks will occur no less than monthly... 1-14-10. 		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369			

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W369	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for two of three clients residing in the facility. [Clients # 1 and #4]</p> <p>The finding includes:</p> <p>1. Observation and staff interview on 12/8/2009 at approximately 8:55 p.m. revealed Client #1 's evening dosage of Miralax (17gms into 8oz of water) was not available to be administered. The licensed practical nurse (LPN) was not sure if she had ordered the medication as it had run out the evening before. The supervisory registered nurse (SRN) who was on site contacted the primary care physician (PCP) and the local pharmacy to initiate the process of securing the medication.</p> <p>In addition, record review and additional interview with the facility 's qualified mental retardation professional (QMRP) and the registered nurse (RN) on 12/10/2009 at approximately 4:50 p.m. revealed the facility 's nursing staff also failed to document Client #1 's missed dosage of Miralax. [See W331]</p> <p>2. Observation on 12/8/2009 at approximately 6:25 p.m. revealed Client #4 's Prolixin (for Schizophrenia) was over poured to approximately 10mls in a small plastic measuring cup. Prior to administering the medication, the licensed practical nurse (LPN) was redirected to check the prescribed dosage. Upon further review, at approximately 6:35 p.m. she confirmed the dosage should have been 4mls and attempted to</p>	W 369	<p>W369</p> <ol style="list-style-type: none"> 1. See responses for W368 above. 2. See responses for W331 (1c) 		

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W 369	Continued From page 20 correct the error. During her attempt at correcting the error, she poured out the excess Prolixin into another small measuring cup and tried to measure out 4mls in the process. The graduated measuring marks on the cup read 2.5mls, 5mls, and then 10mls. There was no 2ml or 4ml marker on the measuring cup.	W 369			
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's medication nurse failed to ensure all biological and drugs were locked when not being prepared. This deficient practice affected the security of the medications for six of six clients residing in the facility. [Clients #1, #2, #3, #4, #5, and #6] The finding includes: Observation on 12/8/2009, between the hours of 6:05 p.m. and 9:00 p.m. revealed the nurse left the clients' medications in an unsecure manner on at least two occasions during the administration of the evening medications. The	W 382	W382 The nurse in question was terminated subsequent to the survey... 1-14-10. Staff training will be conducted with medication passing nurses covering all of the issues cited under W382 and elsewhere in the survey findings... 1-14-10.		

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

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019	
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W 382	Continued From page 21 facility failed to ensure all nursing staff was effectively trained to ensure the security of all medications as evidenced below: 1. At approximately 7:55 p.m. the nurse left the medication ' s filing cabinet unlocked and open when she walked out of the staff ' s office to go wash out the wooden grinding bowl after serving Client #2 his medications. 2. At approximately 8:35 p.m. The nurse left the medication ' s filing cabinet unlocked and open a second time when she walked out the staff ' s office to Client #1 ' s bedroom to administer him his evening medications. On both occasions, the facility ' s house manager (HM), qualified mental retardation professional, and direct care staff were observed entering and exiting the small staff office. Interview with the facility ' s supervisory registered nurse (SRN), registered nurse (RN), the qualified mental retardation professional (QMRP) and house manager (HM) on 12/8/2009 at approximately 9:10 p.m. revealed they were not certain why the medication nurse left the medications and the medication cabinet in an unsecure state during the administration of the evening medications and would implement training immediately to address the problem.	W 382		
W 436	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.	W 436		

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W 436	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility ' s failed to ensure adaptive equipment were being monitored and maintained as recommended for one of three sampled clients. [Client #3]</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Observation on 12/8/2009 and record review and staff interview on 12/10/2009 revealed there was no documented evidence that the treatment plan for the use of Client #3 ' s hand splint was in place. [See W322] 2. Observation on the afternoon of 12/8/2009 at approximately 4:15 p.m. revealed Client #3 received approximately 8oz of water and Boost (nutritional supplement) with his snacks. On both servings, the water and the Boost was provided in a regular clear plastic cup. At no time was staff observed using any adaptive equipment to serve his liquids. In addition, he was also allowed to drink his Boost with a straw. <p>Interview with the facility ' s qualified mental retardation professional (QMRP), the facility ' s registered nurse (RN) and record on 12/10/2009 at approximately 4:25 p.m. revealed, Client #3 ' s Mealtime Feeding Protocol dated 7/2009 recommended he should receive his fluids via a " bolus cup ". Although the Bolus cup was available to the staff at the time of the survey, the QMRP and the RN were not sure why it was not used on the evening of 12/8/2009 during the serving of his snack.</p>	W 436	<p>W436</p> <ol style="list-style-type: none"> 1. As indicated by the surveyor, the hand splint provided by the hospital after the ER visit for Client #3 was put on and used without receiving feedback from the attending physician at the hospital or from the primary care physician. MTS will insure in the future that no such piece of equipment is used without first obtaining feedback from the prescribing specialist or the PCP has to why the equipment is being used and specifically how to use it. The Executive Director will review this issue with the DON and the Lead RN in a formal training session to be conducted by...1-14-10. 2. The Bolus cup does not work for the thickened liquids for Client #3 and the protocol, physician's orders and all other documents will be changed to reflect this...1-14-10. 	

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W 436	Continued From page 23 3. Review of Client #3 's Physical Therapy consult dated 9/15/2009 on 12/10/2009 at approximately 2:55 p.m. revealed the recommendation to " Follow-up with molding for a custom seating system and fabrication of his custom manual wheelchair " . Interview with the facility 's qualified mental retardation professional (QMRP), the registered nurse (RN) and record review on the same day at approximately 2:57 p.m. revealed, the custom molded seating has not been secured to date and there was no documented evidence that the proper referrals were made to ensure the timely follow-up for the custom seating system on his wheelchair as recommended.	W 436	Thickened liquids are provided by spoon for Client #3 as will be reflected by the revised protocol. However, speech pathology may modify the strategy during her review process. If this occurs, staff will be retrained on the new strategy developed by speech pathology... 1-14-10. 3. The wheelchair for Client #3 was ordered in September 2009 from Essential Rehab who fitted him in October of 2009. The initial 719a was rejected by Medicare and is now being processed by Medicaid. MTS will follow up until the chair is obtained and the status of progress will be outlined in the QMRP notes... 1-14-10.	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of six clients residing in the facility. [Client #4] The finding includes: During the evening medication pass on the evening of 12/8/2009 at approximately 6:40 p.m., the facility 's nursing staff was observed using her bare hands to pull Client #4 's medications out of medication cup filled with applesauce. Further observation revealed the nurse failed to	W 455	W455 The grinding bowl method of crushing medications has been replaced by the "Silent Night Pill Crusher". The DON and Lead RN will develop a protocol for using the pill crusher and train nurses on the protocol... 1-14-10.	

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W 455	Continued From page 24 properly clean the wooden mortar and pestle (grinding bowl) after crushing medications between clients. The nurse was not observed employing proper infection control measures during the evening medication pass. [See W331.1] There was no evidence that the facility's staff provided an active program for the prevention and control of infection.	W 455			
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their fluids in the form and consistency as outlined in their physician ' s orders for two of three sampled clients. [Clients #2 and #3] The findings include: 1. Observation on the afternoon of 12/8/2009 at approximately 4:15 p.m. revealed Client #3 received approximately 8oz of water and Boost (nutritional supplement) with his snacks. On both occasions, the water and the Boost was served at regular consistency. At no time was staff observed thickening the fluids prior to serving. In addition, he was also allowed to drink his Boost out of a regular clear plastic cup with a straw. Record review revealed, Client #3 ' s Nutritional assessment dated 10/5/2009 revealed he should receive his fluids in a " nectar to pudding " consistency as he was identified as being at risk	W 474	W474 The speech pathologist will review each liquid thickening regimen to insure that it is appropriate for each person and has clear instructions to follow. Instructions will be made clearer as needed and the speech pathologist will re-train staff... 1-14-10. It is important to note that although there are specifics amounts indicated for "honey consistency" and "nectar consistency", these amounts are estimates. The DON and Lead RN point out that it may take a little more to achieve the required texture. In addition, the longer a mix sits, the thicker it gets. This will be addressed in the upcoming training for staff and medication passing nurses... 1-14-10.		

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W 474	<p>Continued From page 25</p> <p>for aspiration. Additional record review revealed his 12/1/2009 Physician ' s Orders prescribed that he received " thickened liquids " .</p> <p>Interview with the facility ' s qualified mental retardation professional (QMRP) and registered nurse (RN) on 12/10/2009 at approximately 4:20 p.m. revealed there was no way to clarify if Client #3 was to receive his liquids at either a nectar consistency or at a pudding consistency as outlined in his Nutritional assessment.</p> <p>2. Client #3 ' s water was served in a regular consistency during the evening medication administration. Client #3 ' s 11/2009 Meal Time Feeding Protocol prescribed " nectar to pudding " thick consistency for his liquids as he was identified as being at risk for aspiration. [See W331]</p> <p>3. Client #2 ' s water was served at nectar consistency during the med pass. Client #2 ' s 12/1/2009 Physician ' s Order sheets prescribe a " Honey Thick " consistency for all liquids as he was identified as being at risk for aspiration. [See W331]</p>	W 474		
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Health Regulation Administration

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1 000	INITIAL COMMENTS A re-licensure survey was conducted from 12/8/2009 through 12/10/2009. A random sampling of three residents was selected from a resident population of two women and four men with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the resident and administrative records, including the incident reports.	1 000	1a. the nurse that provided water at regular consistency for Client #4 was terminated... 1-14-10. 1b. same as 1a above; additionally, nurses were re-trained on this subject... 1-14-10. The grinding bowl method of crushing medications has been replaced by the "Silent Night Pill Crusher". The DON and Lead RN will develop a protocol for using the pill crusher and train nurses on the protocol... 1-14-10. 1c. a new measuring tool will be obtained that is more precise and exact in measuring liquid medications. Nurses will be trained on the use of the new tool... 1-14-10.	
1 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure all residents received their fluids in the form and consistency as outlined in their physician's orders for two of three sampled residents. [Residents #2 and #3] The findings include: 1. Observation on the afternoon of 12/8/2009 at approximately 4:15 p.m. revealed Resident #3 received approximately 8oz of water and Boost (nutritional supplement) with his snacks. On both occasions, the water and the Boost was served at regular consistency. At no time was staff observed thickening the fluids prior to serving. In addition, he was also allowed to drink his Boost out of a regular clear plastic cup with a straw.	1 042	1d. Privacy in administering medications will be covered in the nurses training on appropriate medication administration... 1-14-10. Additionally, the MTS guide placed in every MAR also addresses the issue... 1-14-10. 1e. the speech pathologist will review each liquid thickening regimen to insure that it is appropriate for each person and has clear instructions to follow. Instructions will be made clearer as needed and the speech pathologist will retrain staff... 1-14-10. It is important to note that although there are specific amounts indicated for "honey consistency" and "nectar consistency", these amounts are estimates. The DON and Lead RN point out that it may take a little more to achieve the required texture. In addition, the longer a mix sits, the thicker it gets. This will be addressed in the upcoming training for staff and medication passing nurses... 1-14-10. 1f. See 1b above. 1g. See 1e above. 1h. and 1i. Securing the medications at all times will be covered in the medication nurse training to be conducted by... 1-14-10. Additionally, the MAR guide provided covers this concern and will be reviewed in the nursing training session as well... 1-14-10.	

Health Regulation Administration

Butte H. Moore Director of Residential Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

1/14/10 (X5) DATE

Health Regulation Administration

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1042	Continued From page 1 Record review revealed, Resident #3's Nutritional assessment dated 10/5/2009 revealed he should receive his fluids in a "nectar to pudding" consistency as he was identified as being at risk for aspiration. Additional record review revealed his 12/1/2009 Physician's Orders prescribed that he received "thickened liquids". Interview with the GHMRP's qualified mental retardation professional (QMRP) and registered nurse (RN) on 12/10/2009 at approximately 4:20 p.m. revealed there was no way to clarify if Resident #3 was to receive his liquids at either a nectar consistency or at a pudding consistency as outlined in his Nutritional assessment. 2. Resident #3's water was served in a regular consistency during the evening medication administration. Resident #3's 11/2009 Meal Time Feeding Protocol prescribed "nectar to pudding" thick consistency for his liquids as he was identified as being at risk for aspiration. [See federal deficiency report citation W331] 3. Resident #2's water was served at nectar consistency during the med pass. Resident #2's 12/1/2009 Physician's Order sheets prescribe a "Honey Thick" consistency for all liquids as he was identified as being at risk for aspiration. [See federal deficiency report citation W331]	1042	1j. the medication was ordered and received in one day. One dose was missed by Client #1. This was reported to the PCP and no ill-effects were noted... 1-14-10. The medication was not ordered in a timely manner because the medication nurses failed to alert the Lead RN, DON or the MTS nursing office when it was in low quantity. To insure there are no repeat episodes: <ul style="list-style-type: none"> The medication passing nursing will be re-trained to alert the Lead RN, DON and/or the nursing office when a medication is in low supply (i.e. 2 or less days of doses in hand) so that reordering can occur... 1-14-10. The Lead RN will conduct periodic cabinet checks to insure that medications are in adequate supply and these periodic checks will occur no less than monthly... 1-14-10. Nursing Office Administrative Support LPNs will conduct similar checks no less than twice monthly to insure the same... 1-14-10. 2. PT will retrain staff on Repositioning Client #2 and on the repositioning protocol during the planned training on... 1-14-10. The QMRP and facility manager will monitor routine implementation during weekly active treatment observations... 1-14-10. Staff will receive on-the-spot training during observations when the protocol is not being followed... 1-14-10. The HMCP will address the repositioning issue as a part of addressing the pressure sore consideration generally. Staff will be trained on the care plan mandates... 1-14-10.	
1055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.	1055		

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1055	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure adaptive equipment were being monitored and maintained as recommended for one of three sampled residents. [Resident #3]</p> <p>The finding includes:</p> <p>Observation on the afternoon of 12/8/2009 at approximately 4:15 p.m. revealed Resident #3 received approximately 8oz of water and Boost (nutritional supplement) with his snacks. On both servings, the water and the Boost was provided in a regular clear plastic cup. At no time was staff observed using any adaptive equipment to serve his liquids. In addition, he was also allowed to drink his Boost with a straw.</p> <p>Interview with the GHMRP 's qualified mental retardation professional (QMRP), the GHMRP 's registered nurse (RN) and record on 12/10/2009 at approximately 4:25 p.m. revealed, Resident #3 's Mealtime Feeding Protocol dated 7/2009 recommended he should receive his fluids via a " bolus cup ". Although the Bolus cup was available to the staff at the time of the survey, the QMRP and the RN were not sure why it was not used on the evening of 12/8/2009 during the serving of his snack.</p>	1055	<p>The Bolus cup does not work for the thickened liquids for Client #3 and the protocol, physician's orders and all other documents will be changed to reflect this...1-14-10.</p>	
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1082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.</p>	1082		
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1082	Continued From page 3 This Statute is not met as evidenced by: Based on observation and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure the provision of cup dispensers for all bathrooms utilized by its residents as required by this section. [Residents #1, #2, #3, #4, #5, and #6] The finding includes: Observation on the morning of 12/8/2009 at approximately 11:25 a.m. revealed, the large bathroom across the hall from Resident #1 and #2 's bedroom was without cup dispensers. Interview with the GHMRP 's staff revealed they were not sure why the cup dispenser was not made in the bathroom.	1082	3503.10 The cup dispenser has been replaced. A new cup dispenser is in place...1-8-10. The facility manager will audit supplies weekly to insure routine availability of needed items and supplies...1-12-10.	
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumiations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure the repair of a loose toilet to prevent any potential for injury for one of six residents residing in the facility. [Resident #4] The findings include: Observation on the morning of 12/8/2009 at approximately 11:30 a.m. revealed the toilet seat	1090		

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I 090	Continued From page 4 in the large bathroom across from Resident #1 's bedroom was extremely loose and could be moved from side to side when manipulated. Interview with the GHMRP 's qualified mental retardation professional (QMRP) on 12/10/2009 at approximately 4:40 p.m. revealed she was not sure why the toilet seat was still broken. She indicated she would have maintenance repair it immediately.	I 090	3504.1 The toilet seat has been repaired... 1-10-10. It should be noted that the facility manager reported the issue prior to the survey based on his weekly environmental inspection but the issue was not addressed by the survey date. MTS will insure timely follow up in the future.	
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on staff interview and record review, the qualified mental retardation professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for six of six of the residents residing in the group home for the mentally retarded person (GHMRP). [Residents #1, #2, #3, #4, #5, and #6] The finding includes: 1. The QMRP failed to ensure staff received effective training to implement repositioning measures and to provide fluids in a form consistent with the developmental needs of a resident. [See federal deficiency report citation W189] 2. The QMRP failed to ensure proper and necessary training for all nursing staff presently employed by the GHMRP. [See federal deficiency report citation W192]	I 183	1. Repositioning training will be implemented by... 1-14-10. 2. Staff will be re-trained on the fluid texture issue for Clients #2 and #3. Speech pathology will conduct the training... 1-14-10. 1. The medication passing LPN in question has been terminated. The new LPN has been trained to insure proper procedures in passing medications... 1-14-10. All of the medication nurses have been re-trained... 1-14-10. Each MAR book has a protocol guide for medication administration that is to be reviewed prior to passing medications. Nurses have been re-trained on the use of the guide... 1-14-10. 2. Repositioning training will be completed... 1-14-10. 3. Fluid texture training by the speech pathologist will occur by... 1-14-10.	

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I 203	Continued From page 6	I 203		
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was provided the opportunity to annually review their written job descriptions as required by this section. [Staff #1, #2, #4, #8, #10, #13, #14]</p> <p>The finding includes:</p> <p>Record review and interview with the GHMRP 's qualified mental retardation professional (QMRP) on 12/9/2009 at approximately 2:50 p.m. revealed seven out of fifteen staff was not provided the opportunity to review their written job description over the past licensure year. [Cross Reference Licensure Citation 3509.2]</p>	I 203		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person</p>	I 206		

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I 206	<p>Continued From page 7</p> <p>(GHMRP) failed to ensure all staff secured an annual health inventory as required by this section. [Staff #1, #2, #4, #5, #8 and #10]</p> <p>The finding includes:</p> <p>Record review and interview with the GHMRP 's qualified mental retardation professional (QMRP) on 12/9/2009 at approximately 2:55 p.m. revealed six out of fifteen staff did not have a current health inventory on file.</p>	I 206	<p>Staff members without current health certificates have been instructed to obtain updated health certificates by... 1-14-10.</p> <p>Health certificate compliance is tracked by HR and the facility manager but MTS will enforce penalties in the future for staff members that fail to renew in a timely manner... 1-10-10.</p>	
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure staff received effective training to implement repositioning measures and to provide fluids in a form consistent with the developmental needs of the resident for two of three sampled residents. [Residents #1, #2 and #3]</p> <p>The findings include:</p> <p>1. Staff interview and record review on 12/10/2009 at approximately 5:20 p.m. revealed, there was no evidence that all staff received training to properly implement Resident #3 ' s repositioning plan. The records reflect, five out of fifteen staff failed to receive training on how to properly implement Resident #3 ' s repositioning treatment requirements as recommended by either the Physical Therapist (PT) or the Wound Care Specialist. [Staff #1, #3, #5, #10, #13] [Cross Reference W331]</p>	I 222	<p>2. PT will retrain staff on Repositioning Client #2 and on the repositioning protocol during the planned training on... 1-14-10.</p> <p>The QMRP and facility manager will monitor routine implementation during weekly active treatment observations... 1-14-10. Staff will receive on-the-spot training during observations when the protocol is not being followed... 1-14-10.</p>	

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I 222	Continued From page 8 2. Staff interview and record review on 12/10/2009 at approximately 5:27 p.m. revealed, there was no evidence that all staff received training to properly implement Resident #2 and Resident #3 's fluid texture requirements over the past certification year. The records reflect, eight out of fifteen staff currently employed failed to receive training on how to properly implement these residents ' fluid texture requirements as prescribed by their primary care physician. [Staff #1, #3, #5, #6, #8, #9, #10 and #12] [Cross Reference W331] [See Federal Report Deficiency Citation W189]	I 222		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person ' s (GHMRP) staff failed to properly implement a resident ' s behavioral interventions as outlined in his Individual Program Plan for one of three sampled residents. [Resident #2] The finding includes: Observation on the evening on 12/8/2009 between the approximate times of 4:00 p.m. and 6:30 p.m. revealed Resident #2 was observed	I 229		

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I 229	<p>Continued From page 9</p> <p>engaging in several episodes of kicking, screaming loudly, and flailing of his arms while sitting in the living room with his house mates.</p> <p>At approximately 4:10 p.m., Resident #2 was observed screaming loudly as he sat in his wheelchair. None of the GHMRP ' s staff walked over to address his vocalizations. By approximately 5:00 p.m., he had two additional episodes of screaming loudly, but on the second occasion he was kicking and flailing his arms during the process. Around 6:00 p.m., the staff was observed holding his arm while implementing a range of motion exercise. Between the sessions, he began to kick with more force, scream and wave his arms.</p> <p>Record review on 12/9/2009 at approximately 10:00 a.m. revealed Resident #2 ' s Behavioral Management Plan dated 6/20/2009 recommended the following interventions for his " Kicking and Screaming " ... " Verbally redirect [him] to his room with supervision if vocalizations are very loud. Provide music and gently talk to him. Give him sensory materials to hold. Change your location around him if the yelling persists. Tell him what activity you are doing. Talk softly. Provide materials he can see, smell, hear or touch. Place soft objects in his hands. Redirect conversation if he begins to yell. Wait for a break in the yelling. If the yelling persists redirect him. Reduce the stimulation around him except for soft music. "</p> <p>Interview with the GHMRP ' s qualified mental retardation professional (QMRP) on 12/9/2009 at approximately 3:30 p.m. revealed the facility ' s staff did not redirect him to his room; did not provide any music to him at the time of the incidents because the television was on instead;</p>	I 229	<p>Staff will be re-trained on proper implementation of Client #2's BSP on...1-14-10. Psychology will conduct the training. Additionally, the QMRP and facility manager separately will observe active treatment implementation and daily supported routines at minimum twice weekly to insure the BSP mandates are followed as needed. Staff failing to do so will receive on the spot training on proper implementation of the strategies and that training will be documented by the QMRP or facility Manager... 1-14-10.</p>	

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I 229	<p>Continued From page 10</p> <p>did not provide him any materials he could see, smell, hear or touch; did not place any soft objects in his hands; nor were they observed making attempts at " reducing the stimulation around him " as outlined in his plan.</p> <p>The facility ' s staff failed to demonstrate the ability to properly manage Resident #2 ' s behavioral outbursts as outlined in his behavioral management plan and as required by this section.</p>	I 229		
I 260	<p>3512.1 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each Residence Director shall maintain current and accurate records and reports as required by this section.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the qualified mental retardation professional (QMRP) failed to ensure an accurate recording of all consent forms for one of three sampled residents. [Resident #3]</p> <p>The finding includes:</p> <p>Observation on the evening of 12/8/2009 at approximately 8:30 p.m. revealed Resident #3 received 1mg of Risperdal as part of his evening regimen. Interview with the licensed practical nurse (LPN) administering the medications on the same night and time revealed the dosage of Risperdal was provided to manage his <i>Intermittent Explosive Disorder (IED)</i>.</p> <p>Review of Resident #3 ' s medical records revealed a " Consent for Treatment with Psychotropic Medication " form was signed by</p>	I 260	<p>The consent form for Resident #3 will be revised to include the medication regimen and potential side effects and represented for review and approval... 1-14-10.</p>	

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1401	Continued From page 13 to address the use of the hand splint, the overall care of the resident ' s sprained wrist, or that the primary care physician was involved in the treatment process.	1401		
1473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on staff interview and record review, the the group home for the mentally retarded person ' s (GHMRP) nursing staff failed to properly document administration errors and notify the Physician of the errors for two of three sampled residents. [Residents #1 and #4] The finding includes: Record review and staff interview on 12/10/2009 at approximately 4:50 p.m. revealed the GHMRP's nursing staff failed to document and notify the attending physician of Resident #1 ' s missed dosage of Miralax and Resident #4's overpouring of Prolixin. The qualified mental retardation professional (QMRP) failed to provide the coordination of services to ensure the attending physician/primary care physician was made aware of the medication errors. [See Federal Report Deficiency Citation W368 and W369]	1473	The medication was not ordered in a timely manner because the medication nurses failed to alert the Lead RN, DON or the MTS nursing office when it was in low quantity. To insure there are no repeat episodes: <ul style="list-style-type: none">The medication passing nursing will be re-trained to alert the Lead RN, DON and/or the nursing office when a medication is in low supply (i.e. 2 or less days of doses in hand) so that reordering can occur...1-14-10.The Lead RN will conduct periodic cabinet checks to insure that medications are in adequate supply and these periodic checks will occur no less than monthly...1-14-10. <ol style="list-style-type: none">See responses for W368 above.See responses for W331 (1c)	

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1260 Continued From page 11

his court appointed legal guardian on 10/2/2009. Although the document was signed by the guardian, the rest of the document was blank. It was not clear if the legal guardian was provided a listing of the medications Resident #3 was receiving and their side effects.

Interview with the GHMRP 's QMRP on 12/10/2009 at approximately 4:40 p.m. revealed she did ensure the review of the psychotropic medications with the legal guardian, but failed to complete the document to reflect the medications that were reviewed and their side effects.

The QMRP failed to ensure accurate documentation of the legal guardian 's consent for Resident #3 's psychotropic regimen.

1260

1401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS

Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

This Statute is not met as evidenced by:
Based on observation, interview and record review the group home for the mentally retarded person (GHMRP) 's medical services failed to ensure the monitoring and oversight of resident 's health and safety needs for two of three sampled residents. [Residents #3 and #4]

The finding Includes:

1. The GHMRP failed to ensure nursing staff were properly trained to administer medications.

1401

The medication was not ordered in a timely manner because the medication nurses failed to alert the Lead RN, DON or the MTS nursing office when it was in low quantity. To insure there are no repeat episodes:

- The medication passing nursing will be re-trained to alert the Lead RN, DON and/or the nursing office when a medication is in low supply (i.e. 2 or less days of doses in hand) so that reordering can occur... 1-14-10.
- The Lead RN will conduct periodic cabinet checks to insure that medications are in adequate supply and these periodic checks will occur no less than monthly... 1-14-10.

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I 401	Continued From page 12 [See federal deficiency report citation W 331] 2. The GHMRP ' s medical staff failed to ensure all medications were administered in accordance with the Physician ' s Orders. [Resident #4] See federal deficiency report citation W 369] 3. Observation on 12/8/2009 at approximately 4:15 p.m. revealed, Resident #3 was wearing a hand splint on his left hand. Record review on 12/9/2009 at approximately 2:20 p.m. revealed, Resident #3 ' s Physician ' s Orders dated 12/1/2009 lists the diagnosis of Osteoporosis. Further record review revealed Resident #3 Physical Therapy assessment dated 9/15/2009 detailed the following diagnosis, " [Resident #3] has been diagnosed with... osteoporosis, degenerative joint disease " . In addition, an incident report dated 11/19/2009 revealed this resident was taken to the ER and was later discharged with the diagnosis of having a sprained wrist. Interview with the GHMRP ' s registered nurse (RN) and the qualified mental retardation professional (QMRP) on 12/10/2009 at approximately 5:00 P.M revealed the resident was wearing the hand splint because he had sprained his wrist. Further interview with the QMRP revealed the GHMRP ' s staff re-positioned him in his bed incorrectly with his left hand left underneath him and slightly to his back. According to the QMRP, this was where she believed Resident #3 sprained his wrist. Additional record review and interview with the GHMRP ' s registered nurse and the QMRP on 12/10/2009 at approximately 5:22 p.m. revealed there was no written evidence on file to substantiate a course of treatment was identified	I 401	1. As indicated by the surveyor, the hand splint provided by the hospital after the ER visit for Client #3 was put on and used without receiving feedback from the attending physician at the hospital or from the primary care physician. MTS will insure in the future that no such piece of equipment is used without first obtaining feedback from the prescribing specialist or the PCP has to why the equipment is being used and specifically how to use it. The Executive Director will review this issue with the DON and the Lead RN in a formal training session to be conducted by...1-14-10. 2. The Bolus cup does not work for the thickened liquids for Client #3 and the protocol, physician's orders and all other documents will be changed to reflect this...1-14-10.	