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

PRINTED: 08/19/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G124		C 07/31/2008

NAME OF PROVIDER OR SUPPLIER: IDI

STREET ADDRESS, CITY, STATE, ZIP CODE: 1230 CONGRESS STREET, SE WASHINGTON, DC 20020

(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 000	INITIAL COMMENTS A monitoring survey was conducted from July 30, 2008 through July 31, 2008. The Plan of Correction submitted by the facility on May 30, 2008 served as the focus for this monitoring survey. All eight of the clients were subject to review, based either on the findings of the April 25, 2008 survey or after new observations were made that were relevant to previously-cited deficient practices. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 10/27/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that needs were met, for two of four clients residing in the facility. (Client #4 and #6) The findings include: 1. Client #4 was observed in his day program on July 30, 2008. He appeared to be asleep between 11:30 AM to 11:45 AM. During that time, the classroom instructor awoke him twice and stated that the client slept a lot. She inquired if the sleepiness may be a potential side effect of the client's medication. The instructor also	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Branch
TITLE: DRS
(X6) DATE: 9.1.08

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 120	Continued From page 1 stated " We do try to keep them awake unless they are like he is now. According to the instructor, the client was visually impaired (blind) and often kept his eyes closed. He would, however, yawn or squeeze your hand if he was awake. Client #4 was observed again from 12:26 PM to 1:00 PM. At 12:26 PM, he appeared to be asleep. When the surveyor asked if he had eaten his lunch, another classroom staff reported that the client had been very sleepy when the food was offered and refused to eat. " He is that way about 50% of the time. His food will be offered again before the plates are sent from the classroom. The instructor indicated that the client also received a Boost Plus supplement which would be offered to him with his food when he awoke. At 12:33 PM, after several verbal prompts from the nurse to wake up, the client opened his eyes and took his medication. Interview with the nurse revealed the medications were Amodopine HCl 10 mg and Sudafed 30 mg which were prescribed for hypotension. At 12:40 PM, the client awakened again, make vocalizations of moderate volume; however, he remained alert for approximately one minute then closed his eyes again. At 12:45 PM, the instructor awakened the client and attempted to feed him again. He refused to eat and kept his eyes closed. At 12:51 AM, the client made a yawning sound, opened his eyes, moved his head, and then closed his eyes again. He remained still and appeared to be asleep until the surveyor ' s departure from the classroom at 1:00PM. When asked if documentation was maintained to	W 120	**W120** **This Standard will be met as evidenced by:** 1. QMRP will follow-up to determine all necessary interventions needed to address client #4's sleeping during the day. In addition, to developing a sleep chart, the QMRP will follow-up with the medical staff to determine if medication changes are needed/warranted. As previously stated QMRP will conduct routine visits to the day program and address concerns as they arise, document visits and demonstrate follow-up actions taken to address specific issues. Additional training will be provided for all QMRP's in this area. Also, reference responses to W331.	8-22-08 ongoing

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W 120	Continued From page 2 baseline Client #4 ' s sleeping behavior, the instructor replied no, his sleep/ awake pattern was not being documented. However, the instructor said they observed Client #4 and implemented his individual program objectives if/when he awakened. Data sheets reflected programs were implemented as indicated by the staff. Later that day (July 30, 2008), the Qualified Mental Retardation Professional (QMRP) was interviewed in the home, beginning at 4:13 PM. He reported that Client #4 was awake when he visited the day program on June 11, 2008. The QMRP stated that he had not asked the day program to collect sleep/ awake pattern data because the day program had not indicated to him that this was a concern. He added that he was previously unaware that Client #4 displayed frequent sleeping behavior while at the day program. Later, he acknowledged that this had been discussed during the April 2008 survey. This is a repeat deficiency. The July 30, 2007 observations and interviews were similar to those of the April 2008 survey. At 4:39 PM, review of the facility ' s " Nurse 24-Hour Report " revealed inconsistent documentation of the client ' s sleep/ awake pattern. [See W331] Review of Client #4 ' s medical and habilitation records failed to show evidence that his interdisciplinary team (medical, psychology, other) had sought to determine the cause of his sleeping behavior and lethargy. See Federal Deficiency Report/ Plan of Correction dated May 30, 2008 - Citations W120 and W331.3. 2. Client #6 was observed at his day program on July 30, 2008. At 11:30 AM he was observed	W 120		

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W 120	Continued From page 3 resting on the repositioning table in the corner of his classroom. Staff provided a two person transfer of the client back to his wheelchair at 11:34 AM. Looking around and appearing alert at 11:45 AM, he was prepared to eat his lunch. Later at 12:40 PM he appeared to be intermittently dozing as he sat in his wheelchair. The nurse indicated that the client had only eaten a few bites of he lunch because he went to sleep. Further interview with the day program nurse revealed the client was administered Tegretol 200 mg and also Valproic Acid 250 mg/5ml syrup, 25 ml (1250 mg) by mouth at noon for seizure disorder, which the Primary Care Physician (PCP) prescribed to be administered at the day program. At 12:50 PM a classroom staff attempted to feed him again, but he continued to sleep. The staff indicated that the client was picky about his food at times and that he received no nutritional supplements at the day program. He ate a few teaspoons of the meal, then went back to sleep. The staff decided to discontinue feeding him because he was too sleepy. Interview with the instructor revealed that sometimes the client was alert and that at other times he slept. Further interview with the instructor reflected that documentation on the frequency of the sleeping was not being recorded and had not been requested. At 12:57 PM, the client remained asleep in his wheelchair. He was then taken back to a table to sit with his peers, where he continued to sleep. The instructor indicated that in order to ensure that the active treatment objectives were implemented, staff must monitor the client closely to determine periods when he was more alert. Day program staff reported that they try to keep the client awake, however sometimes it was challenging.	W 120		

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W 120	Continued From page 4 Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2008), beginning at 4:13 PM reflected that he had not observed the client sleeping during visits to the day program. Additionally, he indicated that the day program had not reported the client's sleeping as a concern. There was no evidence that the day program and the group home had collaborated to determine effective strategies to address the client's sleeping at his day program.	W 120		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of incident reports and review of client records, the facility failed to ensure that all injuries of unknown origin were reported immediately to the State agency for one of the eight clients residing in the facility. (Client #7) The finding includes: On July 30 2008, at 3:45 PM, review of an unusual incident report (dated June 7, 2008) for Client #7 revealed the following: At 4:45 PM a direct care staff (Staff A)"discovered a bruise on Client #7's forehead". The staff documented that she notified the nurse and took	W 153	**W153** **This Standard will be met as evidenced by:** The facility managers will receive additional training on timely report of injuries of unknown origin in accordance with policies and procedures. In addition, the facility fax machine will be program to give receipt for each incident sent out to regulatory agencies and such receipt will be file behind each incident report as evidence.	8.29.08 ongoing

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W 153	Continued From page 5 action. Further review of the incident report revealed that the client's bruise was discovered by Staff C at 5:40 PM when she was making facility rounds and that she provided the initial notification to the nurse of the client's injury. A 6:00 PM nursing note on the incident report documented that first aid was administered, a neurocheck was performed, and that the primary care physician (PCP). Documentation on the incident report reflected that it was not reported to the Department of Health and other governmental agencies until June 9, 2008. There was no evidence that the client's bruise, which was initially believed to be of unknown origin was reported to DOH and other governmental agencies within 24 hours and in accordance with agency policies.	W 153		
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:	W 154	**W154** **This Standard will be met as evidenced by:** QMRP will ensure that incidents are reviewed, investigated, file and submitted to regulatory agencies in accordance with company policies and procedures.	
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 staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services as required by this	W 159	QMRP will ensure that all persons who may have had knowledge or in attendance during the period of an incident is also interviewed. In addition, QMRP will attend incident management training to further refresh techniques and process of incident investigation.	8-29-08 ongoing

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W 159	Continued From page 6 section. The findings include: 1. Cross-refer to W436. The QMRP failed to ensure the oversight and repair of Client #8's wheelchair. 2. Cross-refer to W189 and W192. The QMRP failed to ensure that each employee was provided with continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. 3. Cross-refer to W120. The QMRP failed to ensure collaboration with the interdisciplinary team to develop strategies to address the sleeping of Clients #4 and #6 at their day program. 4. The QMRP failed to ensure collaboration by the interdisciplinary team on Client #3 ' s dietary texture recommendations. Day program observation of the Client #3 on July 30, 2008 at 11:52 AM revealed him lying on his gurney with his elevated at approximately 50 degrees as staff fed him. Interview with staff at revealed that the client was unable to sit and that the head of the gurney was elevated to ensure in this manner to ensure safe swallowing. During lunch at his day program and dinner at the group home on July 30, 2008 the client received a pureed food and regular consistency liquids which he tolerated well. Further interview and the record review however revealed the following inconsistencies between the recommended and provided diet:	W 159	**W159** **This Standard will be met as evidenced by:** 1. Cross-reference response to W436. The QMRP will document the status of each person's wheelchair and adaptive equipment in the monthly and quarterly progress notes. The QMRP and Coordinator will maintain an adaptive equipment book which will show the status of repairs, evaluations and progress made toward securing necessary repairs. 2. Cross reference response to W189 and W192. The QMRP will coordinate and schedule staff training as needed. QMRP and Coordinator will provide oversight, feedback and direction for all staff to support them toward performing their duties effectively, efficiently and competently.	8.14.08

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W 159	Continued From page 7 a) Interview with the Licensed Practical Nurse (LPN) and the Qualified Mental Retardation Professional (QMRP) on how the diet was implemented revealed the client received pureed foods and regular consistency liquids. Further interview with the LPN regarding the current diet order of "mechanical soft - pureed diet" revealed that it was recommended by the Speech and Language Pathologist (SLP). b) Review of the mealtime protocol dated 10/17/08 revealed a dietary order of "mechanical soft/pureed (for all solids)" diet.) The review of a nursing note on the consultation report revealed that the PCP approved the SLP recommendations. This dietary order was verified by a current physician's order for a mechanical soft/pureed, low fat/cholesterol diet. c) On October 15, 2008, the SLP assessed Client #3 to determine his tolerance of ground and pureed foods. She stated that he had been receiving regular ground, (pureed meats) diet. The consultant recommended that "the consistency/texture be changed to a mechanical soft/pureed for all solids to see if there were any changes in the clients frequent coughing. Please document evidence of difficulty. " According to the SLP, the need for a swallowing study was indicated. d) The November 8, 2007 Annual Nutritional Assessment also included the recommendation to continue the Mechanical Soft/Pureed Diet. e) The January 3, 2008 Speech and Language Pathologist Dysphasia/Feeding Protocol Recommendation documented the following: Given the fact that the client "is fed on his gurney	W 159	**W159, Continued...** 3. The QMRP will address and meet with day program to address the dietary need of client #3. QMRP will file supporting documentation in client #3's record. The QMRP will conduct regular visits to the day program, monitor meals and other program activities and document actions taken to address the specific needs of the people. QMRP/nurse will ensure that the day program has a copy of the POS outlining the prescribed diet for client #3. QMRP will follow-up with nurse to ensure that client #3 is scheduled for a swallow study as indicated. Additionally, the QMRP will seek clarification and discuss with the interdisciplinary team the dietary needs of client #3.	8.14.08 ongoing

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W 159	Continued From page 8 and is not at a 90 degree angle (the ideal position for feeding) and basically is positioned on his side or back at approximately 45 degrees angle, it is recommended that he continue to receive the recommended food consistency that was approved on October 15, 2007. The consistency should remain unchanged, that is, mechanical soft diet as outline in the observation report conducted until further notice. In the event that dysphagia issues changes, and the client is referred to this consultant, appropriate notification will be forthcoming." At the time of the survey, the client was receiving all solid foods in a pureed textured. It could not be verified however which foods, if any were to be given to the client in a mechanical soft texture. There was no evidence the interdisciplinary team had collaborated on the client dietary order/instructions to ensure clear interpretation by all individuals who may be assigned to prepare the client's food and/or feed him.	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 interview and record review, the facility failed to ensure effective training on reporting of unusual incidents and injuries for two of eight clients residing in the facility. (Clients #5 and #7) The findings include: 1. Cross refer to W153. The review an unusual	W 189	**W189** **This Standard will be met as evidenced by:** QMRP will encourage the staff to report incidents in accordance to regulatory requirements. QMRP and/or Coordinator will also coordinate training on adaptive equipment to include but not limited to; bedrails, use of bedrails, checking of bedrails, documentation, incident reporting procedures and expectations. QMRP will take immediate actions (i.e. training, disciplinary action) moving forward for all staff who fail to implement the policies as outlined. Also, reference response to W159.	8.24.08 ongoing

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W 189	Continued From page 9 incident report dated June 7, 2008 revealed Client #7 sustained a bruise of unknown origin which was not reported timely by the staff who initially observed the client's injury. Interview with the QMRP on July 31, 2008 at 3:45 PM and the review of the facility's investigative report dated June 11, 2008 revealed that the staff assigned to Client #7 indicated that she did not closely observe the client to determine if he had a bruise or other visible injury when she arrived on duty. The incident report stated that staff observed the client's bruise after giving him a bath at 4:45 PM; however she did not report it to the nurse immediately . The client's bruise was later discovered at 5:30 PM by a staff while making facility rounds. The investigative report further stated that the staff had not observed a bruise on the client's forehead during earlier facility rounds at 4:00 PM. Interview with the QMRP revealed all staff had been trained to implement the agency policy of visual observation of the clients at the beginning of the shift. There was no evidence the staff was timely and effectively trained on the policy to immediately report a client's injury to the nurse. 2. The review of an unusual incident reports on July 30, 2008 revealed on June 17, 2008 an open area was discovered on Client #5' s toe which staff failed to immediately report. The incident report reflected that the staff providing care to the client at 6:15 AM observed a 1 cm opening on Client #5's right great toe. He immediately reported the client's injury to the nurse on duty who assessed the area, cleansed it and treated it with antibiotic. The review of the investigative report revealed	W 189		

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W 189	Continued From page 10 that a staff present during the 2:00 PM to 10:00 PM staff on June 16, 2008 acknowledged having seen the open area while bathing the client, however did not report the injury to the LPN on duty. This staff informed the QMRP that the injury may have occurred while staff was transferring him from his hospital bed to his wheelchair. The review of training records revealed it bed rail/bed safety was last reviewed on March 12, 2008. Interview with the QMRP on July 31, 2008 at 12:45 PM revealed that agency policy requires that the nurse be notified immediately of all client injuries and that incident reports be completed immediately when a client is injured. Review of staff training records revealed a session on Timely Reporting of Incidents was conducted on July 4, 2008. There was no evidence however the staff was timely trained to ensure effective implementation of these policies.	W 189		
W 192	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 effectively train staff to implement emergency measures for eight of eight clients in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8) The finding includes: On July 30, 2008 at approximately 3:00 PM Cardiopulmonary Resuscitation (CPR) and first aid training was requested for new employees	W 192	**W192** **This Standard will be met as evidenced by:** Both S2 and S5 will be scheduled to attend CPR/First Aid training. The Training Coordinator will track and provide written documentation to the QMRP/Coordinator to verify attendance and certification. The Training Coordinator will send notices to Home Managers at least three months prior to the expiration date to ensure that staff are scheduled to attend trainings prior to the expiration dates. All new employees are expected to complete CPR/First Aid training during the orientation period.	9.24.08 ongoing

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NAME OF PROVIDER OR SUPPLIER I D I		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	

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W 192	Continued From page 11 observed working with the clients earlier that day. Interview with the Qualified Mental Retardation Professional indicated that the records would be provided by the administrative office on the next day. The review of the records provided on the July 31, 2008 revealed no evidence that S2 and S5 had CPR and first aid certification. Further interview with the QMRP indicated that the July 2008 classes were cancelled and had rescheduled for August 2008.	W 192		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide preventive and general medical care for two of eight clients residing in the facility. (Clients #3 and #6) The findings include: 1. The facility failed to ensure recommended medical follow-up for Client #3 after his emergency room evaluation Review of an unusual incident report from the day program which was dated July 10, 2008 revealed the following information concerning Client #3: At approximately 12:00 PM, Client #3 was observed coughing while being fed a pureed meal for lunch. Feeding was discontinued and the nurse was called to assess him. His vital signs were taken and he appeared to be stable. At 1:20 PM the client began to shake his head back	W 322	**W322** **This Standard will be met as evidenced by:** 1. RN will address timely scheduling of follow-up medical appointments with all LPN staff. RN will provide additional training on documentation and timely follow-up actions. QMRP will also be required to monitor and track the recommendations following discharge. Also, reference response to W159	9.17.08 ongoing

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

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FORM APPROVED
OMB NO. 0938-0391

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W 322	Continued From page 12 and forth and he was taken to the nurse for further evaluation. Vital signs were again checked and the client appeared to be in discomfort. Emergency Medical Services (EMS)was called and transported him to a local hospital for evaluation. The review of the hospital discharge summary revealed the client was admitted to the emergency room (ER) for observation at 2:00 PM where he was diagnosed with coughing (primary) and dehydration (secondary). He was discharged to his group home in stable condition at 5:40 PM. Instructions provided by the ER included a recommendation that the client be evaluated by the primary care physician in 2-3 days. Interview with the LPN on 7/31/08 and the record review at approximately 2:50 PM revealed that Client #3 was last evaluated by the PCP on June 21, 2008. [See also W159, 4] 2. The facility failed to ensure Client #6 received seizure monitoring in accordance with the established protocol. a) (Cross refer to W120.2) Observation of Client #6 at his day program on July 30, 2008 revealed him sleeping when staff attempted to feed him lunch. Interview with the nurse revealed that he was prescribed to receive Tegretol 200 mg at noon and Valproic Acid 250 mg/5ml syrup, 25 ml (1250 mg) by mouth at noon for seizures. Further interview with the day program nurse revealed the client had two recent seizures at the day program (May 21, 2008 - 1 minute and 15 seconds; June 24, 2008 - 5 seconds) and that interoffice communications had been sent to the group home.	W 322	**W322, Continued...** 2. Cross reference response to W120.2. The RN will also provide additional training on seizure documentation, scheduling and monitoring of anticonvulsant levels. Failure to adhere to the standards could result in disciplinary action. RN will review client records on a regular basis provide feedback and direction for LPN staff. Seizure documentation will be checked by the LPN at the end of each month to ensure that documentation is complete. The overnight LPN also is responsible for reviewing and identifying discrepancies as they arise.	9.17.08 ongoing

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

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W 322	Continued From page 13 The review of June 2008 medication orders confirmed that the Client #6 was prescribed Carbamazepine 300 mg in the morning, 200 mg at noon, and 200 mg in the evening for seizure disorder. Additionally, he was prescribed prescribed Valproic Acid 250 mg/5ml syrup, 27 ml (1350 mg) in the morning and 25 ml (1250 mg) at noon and in the evenings. On July 31, 2008 10:27 AM the residential LPN confirmed that the client receives these medications. A March 20, 2008 neurology consultation report revealed that the client was stable and should continue on his same seizure medications. The seizure log reflected that the client hand a 1 minute and 20 second seizure on April 11, 2008. The last prior documented seizure was in January 2007. Record review revealed that the seizures reported by the day program were recorded in the nursing progress notes, however had not been documented on the seizure log maintained by the group home. b) The facility failed to ensure timely monitoring of Client #6's anticonvulsant levels. The review of the physician's orders dated 6/1/08 indicated that Tegretol and Valproic levels should be monitored every three months. The review of Tegretol and Valproic Acid levels revealed the following: Depakene: 1/12/08 - 41.7 mcg/ml (normal range: 50 - 100 mcg/ml. A nursing note reflected that the primary care physician was notified on	W 322	**W331** **This Standard will be met as evidenced by:** The facility nurse will receive additional training on the importance of providing timely nursing services, documenting interventions, and following recommendations. Also, reference response to W322. The QMRP and nursing staff will develop a sleep monitoring form to track and document the sleeping patterns of client #4. The QMRP and nurse will be expected to review the documentation and provide necessary follow-up. As outlined in the previous plan of correction, both the QMRP and nurse are expected to conduct routine visits to the day program, address issues as they arise and document actions taken. QMRP will also receive additional training in this area to ensure compliance with this standard. Information will be reviewed by	9.17.08 ongoing

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 322	Continued From page 14 1/22/08. Depakene: 5/31/08 - 21.0 mcg/ml. There was no evidence that the Depakene level was monitored every three months as prescribed. Tegretol: 5/31/08 - 5 mcg/ml (normal range: 4 - 12) Thru interview with the LPN on July 31, 2008 and the record review it was determined that the PCP was routinely telephoned to inform him of the results of lab tests. The LPN also indicated that the PCP made monthly visits to monitor the client and was accompanied by the Director of Nursing. Review of progress notes dated April 10, 2008, May 3, 2008 , and June 21, 2008 reflected that the client was stable and had no new problems. The June 21, 2008 medical review noted that the client's last seizure was in December 2006. There was no evidence that the PCP was aware of the client seizure activity which began on April 11, 2008. The facility failed to ensure Client #6's seizure management protocol which required timely monitored of abnormal anticonvulsant levels and seizure activity was implemented.	W 322	the interdisciplinary team to determine what if any additional strategies are needed to address this concern. RN will implement disciplinary action as warranted for failure to document required nursing interventions should documentation concerns continue. Cross reference response to W120 and W322	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely nursing services to meet client needs, for four of the eight clients in the sample. (Clients #3, 4, 5, and #6)	W 331		

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

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W 331	Continued From page 15 The findings include: 1. The facility's nursing staff failed to consistently document Client #4 ' s sleep. Cross-refer to W120. On July 30, 2008, Client #4 was observed sleeping and/or showing signs of lethargy at his day program. His direct support staff indicated that this was routine behavior. In the residence later that day, at approximately 4:30 PM, the evening LPN stated that overnight nurses were expected to document the client ' s sleep pattern in their " Nurse 24-Hour Report. " At 4:39 PM, review of that log book for the period June 16, 2008 - July 29, 2008 revealed that overnight nurses failed to document the client ' s sleep on 22 of the 44 nights (June 17, 18, 21, 22, 23, 25, 26 and July 1, 3, 5, 13, 14, 15, 16, 17, 20, 21, 23, 24, 26, 27 and 28, 2008). This is a repeat deficiency. In the April 25, 2008 survey, day program direct support staff had questioned whether the client was sleeping through the night, because he slept through much of the day. The day program nurse had also indicated that the client was drowsy and/or slept often. The QMRP stated that the nurses were responsible for documenting the client ' s sleep pattern. The April 25, 2008 survey, however, revealed that overnight nurses had not been consistently documenting his sleep pattern. The facility ' s May 30, 2008 Plan of Correction included the following: " Residential LPN will maintain regular contact with the day program nurse ... LPN/RN will continue to conduct routine visits to the day program, conduct observations and address concerns as they arise. " Interviews with day program and residential nurses on July	W 331		

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

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W 331	Continued From page 16 30, 2008 revealed that to date, there had been no observation visits by residential nurses to the day program since the April survey. In addition, residential nurses were previously unaware that Client #4 displayed frequent sleeping behavior while at the day program. See Federal Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations W120.2 and W331.3. 2. Cross refer to W120. Client #6 was observed sleeping at mealtime at his day program on July 30, 2008. The nurse indicated that the client had only eaten a few bites of he lunch because he went to sleep. Staff commented that they did not know if the client slept well at night. Interview with the residential nurse revealed that the facility was not aware of the extent of Client #6's sleeping at his day program. There was no evidence measures had been implemented to monitor the client's sleeping while at the day program to determine the client's response to his seizure medication administered at noon. 3. Cross refer to W322. The facility's nursing services failed to ensure the PCP was informed/aware of Client #3's July 10, 2008 emergency room visit. The review of the hospital discharge summary revealed the client was admitted to the emergency room (ER) for observation at 2:00 PM where he was diagnosed with coughing (primary) and dehydration (secondary). He was discharged to his group home in stable condition at 5:40 PM. Interview with the LPN on July 31, 2008 at approximately 2:50 PM revealed that it could not be verified that the PCP was aware of the that the	W 331		

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

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OMB NO. 0938-0391

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W 331	Continued From page 17 client's was treated at emergency room. Although the nursing progress notes revealed that the client was monitored for signs and symptoms of the diagnosed concerns, there was no evidence that the Primary care physician (PCP) was notified of the ER visit or recommendations for health care follow-up in 2 - 3 days. There was no evidence the the client received nursing services in accordance with his needs. 4. Th review of an unusual incident report dated June 17, 2008 revealed that Client #5 was observed to have a 1 cm open area on his right great toe. The incident report documented that the day nurse was notified and would schedule a appointment. The corresponding nursing progress note dated June 17, 2008 (8:00 AM) revealed the client had no sign of infection. Further review of the nursing progress notes failed to provide documentation reflecting monitoring of the open area on the client right great toe again until June 19, 2008. There was no evidence the client was monitored closely by the nurse after his injury of unknown origin to his right great toe. NOTE: Interview with the nurse on July 31, 2008 at 1:35 PM revealed a podiatry appointment was scheduled for June 23, 2008. The review of a podiatry progress dated June 23, 2008 revealed dried blood on dorsal 4th toe right foot and first toe right foot. Neosporin Cream was prescribed to be applied to both toes for three weeks. 5. Cross refer to W322.2 The facility's nursing services failed to ensure that Client #6's seizures reported by the day program were documented on the seizure log. In the Interview with the day program nurse, the review of interoffice	W 331		

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

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W 331	Continued From page 18 communications to the group home and group home progress notes it was revealed that Client #6 had seizures at the day program on May 21,2008 and June 24, 2008. The facility's nursing services failed to ensure that the seizures were documented on the seizure log. There was also no evidence that nursing services informed the primary care physician (PCP) was informed of the client's new seizures activity, which began on April 11, 2008.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client received a physical examination by a Registered Nurse, for two of the eight clients residing in the facility. (Clients #3 and #4) The findings include: 1. On July 31, 2008, at 11:22 AM, review of Client #4 ' s medical records revealed than an LPN had performed a "3rd Quarter Nursing Assessment" on July 24, 2008). The client ' s record reflected an Annual Nursing Assessment dated September 30, 2008, prepared by a consulting RN. The consulting RN had documented quarterly re-assessments on December 31, 2007 and March 30, 2008. Since that time, the facility hired a new RN. At 11:47 AM, the facility ' s current RN was interviewed by telephone. She	W 336	**W336** **This Standard will be met as evidenced by:** The RN will complete quarterly assessments for all clients in accordance to the schedule. The Director of Nursing will provide additional training if needed for the RN to ensure compliance with this standard.	9.25.08 ongoing

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

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W 336	Continued From page 19 acknowledged that she had not performed a physical assessment of Client #4 (due in June 2008). She further indicated that she was "overdue" on several individuals ' quarterly assessments. 2. On July 31, 2008, a 3:10 PM, review of Client #3's medical records revealed that an LPN had performed a Second Quarter Nursing Assessment on May 15, 2008. Interview with the LPN at that time confirmed that she had assessed the client. At 11:47 AM, the facility's current RN was interviewed by telephone. She acknowledged that she had not performed the client's physical assessment which was due in May 2008.	W 336		
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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to to ensure that the wheelchair recommended for one of eight clients residing in the facility was maintained in good repair. (Client #8) The finding includes: Observation of Client #8's wheelchair at the residential facility on July 30, 2008 at approximately 8:45 AM revealed multiple torn	W 436	**W436** **This Standard will be met as evidenced by:** As previously stated the QMRP and Coordinator are responsible for addressing all wheelchair concerns. All repairs and request for repairs will be maintained in the Adaptive Equipment book. QMRP/Coordinator will update the records whenever repairs are made and actions are taken toward securing necessary repairs and adaptive equipment. The QMRP will document the status of adaptive equipment monthly and quarterly. QMRP will provide additional staff training to ensure that all staff fully understand the expectations related to documentation and reporting wheelchair concerns.	8.11.08 ongoing

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

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W 436	Continued From page 20 edges on the vinyl covering and exposed supportive foam of the foot box. During the previous survey observations (April 24, 2008 and April 25, 2008) at the residential facility, the footrests on Client #8's were also observed to have the outer layer torn and the supportive foam exposed in several areas. The review of the May 30, 2008 Plan of correction indicated that staff are expected to report wheelchair concerns immediately and document on the wheelchair monitoring form weekly. The QMRP(Qualified Mental Retardation Professional)/Home Manager must then follow-up to address the concern. Interview with the QMRP on July 30, 2008 revealed that these are still the required procedures. Additionally, record review on July 31, 2008 4:30 PM, failed to provide evidence that oversight and follow-up had occurred to ensure that the observed damage to the client's wheelchair footrests had been repaired. See Federal Deficiency Report/ Plan of Correction dated May 30, 2008 - Citation W436.4	W 436		

PRINTED: 08/19/2008
FORM APPROVED

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	HFD03-0098		C 07/31/2008
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I 000	INITIAL COMMENTS A monitoring survey was conducted from July 30, 2008 through July 31, 2008. The Plan of Correction (PoC) submitted by the facility on May 30, 2008 served as the focus for this monitoring survey. All eight of the residents were subject to review, based either on the findings of the April 25, 2008 survey or after new observations were made that were relevant to previously-cited deficient practices. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000	**3510.5(d)** **This Statute will be met as evidenced by:**	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and review of personnel records made available, the GHMRP failed to ensure that all staff had received certification in Cardiopulmonary resuscitation (CPR) and first aid, in accordance with agency policies for eight of eight residents in the facility. (Residents #1, #2, #3, #4, #5, #6, #7 and #8) The finding includes: On July 30, 2008 at approximately 3:00 PM, Cardiopulmonary Resuscitation (CPR) and first aid training records was requested for new employees observed working with the residents earlier that day. Interview with the Qualified	I 227	Reference response to federal deficiency report W192. (Both S2 and S5 will be scheduled to attend CPR/First Aid training. The Training Coordinator will track and provide written documentation to the QMRP/Coordinator to verify attendance and certification. The Training Coordinator will send notices to Home Managers at least three months prior to the expiration date to ensure that staff are scheduled to attend trainings prior to the expiration dates. All new employees are expected to complete CPR/First Aid training during the orientation period.)	9.24.08 ongoing

Health Regulation Administration

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

TITLE DES

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I 227	Continued From page 1 Mental Retardation Professional (QMRP) indicated that the records would be provided by the administrative office on the next day. The review of the records provided on the July 31, 2008 revealed no evidence that S2 and S5 had current CPR and first aid certification. Further interview with the QMRP confirmed that the July 2008 classes were cancelled and had been rescheduled for August 5, 2008. See State Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations 3510.5 (d)	I 227		
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 interview and record review, the facility failed to ensure effective training on reporting of unusual incidents and injuries for two of eight residents residing in the facility. (Residents #5 and #7) The findings include: 1. Cross refer to Federal Deficiency Report W153. The review an unusual incident report dated June 7, 2008 revealed Resident #7 sustained a bruise of unknown origin which was not reported timely by the staff who initially observed the resident's injury.	I 229	**3510(f) Staff Training** **This Statute will be met as evidenced by:** 1. Reference response to Federal Deficiency Report W153.	8-29-08 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 07/31/2008
NAME OF PROVIDER OR SUPPLIER I D I	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		

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I 229	Continued From page 2 Interview with the QMRP on July 31, 2008 at 3:45 PM and the review of the facility's investigative report dated June 11, 2008 revealed that the staff assigned to Resident #7 indicated that she did not closely observe the resident to determine if he had a bruise or other visible injury when she arrived on duty. The incident report stated that the staff observed the resident's bruise after giving him a bath at 4:45 PM; however she did not report it to the nurse immediately . The resident's bruise was later discovered at 5:30 PM by another staff while making facility rounds. The investigative report further stated that the staff who reported the bruise on the resident's forehead to the nurse had not observed a bruise during earlier facility rounds at 4:00 PM. Interview with the QMRP revealed all staff had been trained to implement the agency policy of visual observation of the clients at the beginning of the shift. There was no evidence the staff was effectively trained on this policy to immediately report a resident's injury to the nurse. 2. The review of an unusual incident on July 30, 2008 revealed on June 17, 2008 an open area was discovered on Resident #6' s toe which staff failed to report immediately. The incident report reflected that the staff providing care to the resident at 6:15 AM observed a 1 cm opening on Resident #5's right great toe. He immediately reported the resident's injury to the nurse on duty who assessed the area, cleansed it and treated it with antibiotic. The investigative report revealed that one of two staff present during the 2:00 PM to 10:00 PM staff on June 16, 2008 acknowledged having seen the open area while bathing the resident, however he did not report the injury to the LPN on	I 229		

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FORM APPROVED

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I 229	Continued From page 3 duty. This staff informed the QMRP that the injury may have occurred while staff was transferring him from his hospital bed to his wheelchair. The review of training records revealed that bed rail/bed safety was last reviewed on March 12, 2008. Interview with the QMRP on July 31, 2008 at 12:45 PM revealed that agency policy requires that the nurse be notified immediately of all resident injuries and that incident reports be completed immediately when a resident is injured. Review of staff training records revealed a session on Timely Reporting of Incidents was conducted on July 4, 2008. There was no evidence however the staff was timely trained to ensure effective implementation of these policies. See State Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations 3510.5(f), I229	I 229		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services. The findings include: On July 30, 2008 at approximately 3:00 PM personnel document records were requested	I 274	**3513.1(e)** **This Statute will be met as evidenced by:** Contracts for all consultants are maintained in the administrative office. To ensure timely submission, copies of the contracts have also been provided to the administrative assistant at both offices to ensure that a copy of the documents are provided as requested.	8.8.08 ongoing

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I 274	Continued From page 4 from the administrative office. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that they would be provided on July 31, 2008. The requested records included agreements or contracts for the Podiatrist (C1) and the Speech Therapist (C2). At the time of the survey exit on July 31, 2008 the agreements/contracts for the Podiatrist and the Speech Therapist had not been provided to the surveyors for review. According to the Plan of Correction dated May 30, 2008 (for the 4/25/08 survey) "The GHMRP will ensure that a copy of the podiatrist and speech therapist are on file and available for review." See State Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations 3413.1(e), I375	I 274		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medical and nursing services accordance with the needs of Residents #3, #4, #5 and #6. The findings include: 1. The facility failed to ensure Resident #6 received seizure monitoring in accordance with the established protocol.	I 401	**3520.3** **This Statute will be met as evidenced by:** Reference response to W120.2, W189, W331 and W322 on the Federal Deficiency Report.	9.24.08 ongoing

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I 401	Continued From page 5 a) (Cross refer to W120.2 on Federal Deficiency Report) Observation of Resident #6 at his day program on July 30, 2008 revealed him sleeping when staff attempted to feed him lunch. Interview with the nurse revealed that he was prescribed to receive Tegretol 200 mg at noon and Valproic Acid 250 mg/5 ml syrup, 25 ml (1250 mg) by mouth at noon for seizures. Further interview with the day program nurse revealed the client had two recent seizures at the day program (May 21, 2008 - 1 minute and 15 seconds; June 24, 2008 - 5 seconds) and that interoffice communications had been sent to the group home. The review of June 2008 medication orders confirmed that the Resident #6 was prescribed Carbamazepine 300 mg in the morning, 200 mg at noon, and 200 mg in the evening for seizure disorder. Additionally, he was prescribed prescribed Valproic Acid 250 mg/5 ml syrup, 27 ml (1350 mg) in the morning and 25 ml (1250 mg) at noon and in the evenings. On July 31, 2008 10:27 AM the residential LPN confirmed that the client receives these medications. A March 20, 2008 neurology consultation report stated that the client was stable and should continue on his same seizure medications. The seizure log reflected that the client hand a 1 minute and 20 second seizure on April 11, 2008. The last prior documented seizure was in January 2007. Record review revealed that the seizures reported by the day program were recorded in the nursing progress notes, however had not been documented on the seizure log maintained by the group home.	I 401		

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I 401	Continued From page 6 b) The facility failed to ensure timely monitoring of Resident #6's anticonvulsant levels. The review of the physician's orders dated 6/1/08 indicated that Tegretol and Valproic levels should be monitored every three months. The review of Tegretol and Valproic Acid levels revealed the following: Depakene: 1/12/08 - 41.7 mcg/ml (normal range: 50 - 100 mcg/ml. A nursing note reflected that the primary care physician was notified on 1/22/08. Depakene: 5/31/08 - 21.0 mcg/ml. There was no evidence that the Depakene level was monitored every three months as prescribed. Tegretol: 5/31/08 - 5 mcg/ml (normal range: 4 - 12mcg/ml) Thru interview with the LPN on July 31, 2008 and the record review it was determined that the PCP was routinely telephoned to inform him of the results of lab tests. The LPN also indicated that the PCP made monthly visits to monitor the client and was accompanied by the Director of Nursing. Review of progress notes dated April 10, 2008, May 3, 2008 , and June 21, 2008 reflected that the client was stable and had no new problems. The June 21, 2008 medical review noted that the client's last seizure was in December 2006. There was no evidence that the PCP was aware of the client seizure activity which began on April 11, 2008. The facility failed to ensure Resident #6's seizure management protocol which required timely monitored of abnormal anticonvulsant levels and	I 401		

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I 401	Continued From page 7 seizure activity was implemented. 2. The facility's nursing staff failed to consistently document Resident #4's sleep. Cross-refer to W120. On July 30, 2008, Resident #4 was observed sleeping and/or showing signs of lethargy at his day program. His direct support staff indicated that this was routine behavior. In the residence later that day, at approximately 4:30 PM, the evening LPN stated that overnight nurses were expected to document the client ' s sleep pattern in their " Nurse 24-Hour Report. " At 4:39 PM, review of that log book for the period June 16, 2008 - July 29, 2008 revealed that overnight nurses failed to document the client ' s sleep on 22 of the 44 nights (June 17, 18, 21, 22, 23, 25, 26 and July 1, 3, 5, 13, 14, 15, 16, 17, 20, 21, 23, 24, 26, 27 and 28, 2008). This is a repeat deficiency. In the April 25, 2008 survey, day program direct support staff had questioned whether the client was sleeping through the night, because he slept through much of the day. The day program nurse had also indicated that the client was drowsy and/or slept often. The QMRP stated that the nurses were responsible for documenting the client ' s sleep pattern. The April 25, 2008 survey, however, revealed that overnight nurses had not been consistently documenting his sleep pattern. The facility ' s May 30, 2008 Plan of Correction included the following: " Residential LPN will maintain regular contact with the day program nurse ... LPN/RN will continue to conduct routine visits to the day program, conduct observations and address concerns as they arise. " Interviews with day program and residential nurses on July 30, 2008 revealed that to date, there had been no observation visits by residential nurses to the day	I 401		

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I 401	Continued From page 8 program since the April survey. In addition, residential nurses were previously unaware that Resident #4 displayed frequent sleeping behavior while at the day program. See Federal Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations W120.2 and W331.3. 3. Cross refer to Federal Deficiency Report - W120. Resident #6 was observed sleeping at mealtime at his day program on July 30, 2008. The nurse indicated that the client had only eaten a few bites of he lunch because he went to sleep. Staff commented that they did not know if the client slept well at night. Interview with the residential nurse revealed that the facility was not aware of the extent of Resident #6's sleeping at his day program. There was no evidence measures had been implemented to monitor the client's sleeping while at the day program to determine the client's response to his seizure medication administered at noon. 4. Cross refer to Federal Deficiency Report - W322.1 The facility's nursing services failed to ensure the PCP was informed/aware of Resident #3's July 10, 2008 emergency room visit. The review of the hospital discharge summary revealed the client was admitted to the emergency room (ER) for observation at 2:00 PM where he was diagnosed with coughing (primary) and dehydration (secondary). He was discharged to his group home in stable condition at 5:40 PM. Interview with the LPN on July 31, 2008 at approximately 2:50 PM revealed that it could not be verified that the PCP was aware of the that the client's was treated at emergency room. Although	I 401		

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I 401	Continued From page 9 the nursing progress notes revealed that the client was monitored for signs and symptoms of the diagnosed concerns, there was no evidence that the Primary care physician (PCP) was notified of the ER visit or recommendation for health care follow-up in 2 - 3 days. There was no evidence the the client received nursing and medical services in accordance with his needs. 5. The review of an unusual incident report dated June 17, 2008 revealed that Resident #5 was observed to have a 1 cm open area on his right great toe. The incident report documented that the day nurse was notified and would schedule a appointment. The corresponding nursing progress note dated June 17, 2008 (8:00 AM) revealed the client had no sign of infection. Further review of the nursing progress notes failed to provide documentation reflecting monitoring of the open area on the client right great toe again until June 19, 2008. There was no evidence the client was monitored closely by the nurse after his injury of unknown origin to his right great toe. Interview with the nurse on July 31, 2008 at 1:35 PM revealed a podiatry appointment was scheduled for June 23, 2008. The review of a podiatry progress dated June 23, 2008 revealed dried blood on dorsal 4th toe right foot and first toe right foot. Neosporin Cream was prescribed to be applied to both toes for three weeks.	I 401		

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I 000	INITIAL COMMENTS A monitoring survey was conducted from July 30, 2008 through July 31, 2008. The Plan of Correction (PoC) submitted by the facility on May 30, 2008 served as the focus for this monitoring survey. All eight of the residents were subject to review, based either on the findings of the April 25, 2008 survey or after new observations were made that were relevant to previously-cited deficient practices. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services. The findings include: On July 30, 2008 at approximately 3:00 PM personnel document records were requested from the administrative office. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that they would be provided on July 31, 2008. The requested records included	I 274	**This Statute will be met as evidenced by:** Contracts for all consultants are maintained in the administrative office. To ensure timely submission, copies of the contracts have also been provided to the administrative assistant at both offices to ensure that a copy of the documents are provided as requested.	8.8.08 ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 274	Continued From page 1 agreements or contracts for the Podiatrist (C1) and the Speech Therapist (C2). At the time of the survey exit on July 31, 2008 the agreements/contracts for the Podiatrist and the Speech Therapist had not been provided to the surveyors for review. According to the Plan of Correction dated May 30, 2008 (for the 4/25/08 survey) "The GHMRP will ensure that a copy of the podiatrist and speech therapist are on file and available for review." See State Deficiency Report/ Plan of Correction, dated May 30, 2008 - Citations 3413.1(e), I375	I 274		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medical and nursing services accordance with the needs of Residents #3, #4, #5 and #6. The findings include: 1. The facility failed to ensure Resident #6 received seizure monitoring in accordance with the established protocol. a) (Cross refer to W120.2 on Federal Deficiency Report) Observation of Resident #6 at his day program on July 30, 2008 revealed him sleeping when staff attempted to feed him lunch. Interview	I 401	**3520.3** **This Statute will be met as evidenced by:** **Reference response to W120.2, W189, W331 and W322 on the Federal Deficiency Report.**	9-25-08 ongoing

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I 401	Continued From page 2 with the nurse revealed that he was prescribed to receive Tegretol 200 mg at noon and Valproic Acid 250 mg/5 ml syrup, 25 ml (1250 mg) by mouth at noon for seizures. Further interview with the day program nurse revealed the client had two recent seizures at the day program (May 21, 2008 - 1 minute and 15 seconds; June 24, 2008 - 5 seconds) and that interoffice communications had been sent to the group home. The review of June 2008 medication orders confirmed that the Resident #6 was prescribed Carbamazepine 300 mg in the morning, 200 mg at noon, and 200 mg in the evening for seizure disorder. Additionally, he was prescribed prescribed Valproic Acid 250 mg/5 ml syrup, 27 ml (1350 mg) in the morning and 25 ml (1250 mg) at noon and in the evenings. On July 31, 2008 10:27 AM the residential LPN confirmed that the client receives these medications. A March 20, 2008 neurology consultation report stated that the client was stable and should continue on his same seizure medications. The seizure log reflected that the client hand a 1 minute and 20 second seizure on April 11, 2008. The last prior documented seizure was in January 2007. Record review revealed that the seizures reported by the day program were recorded in the nursing progress notes, however had not been documented on the seizure log maintained by the group home. b) The facility failed to ensure timely monitoring of Resident #6's anticonvulsant levels. The review of the physician's orders dated 6/1/08	I 401		

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I 401	Continued From page 3 indicated that Tegretol and Valproic levels should be monitored every three months. The review of Tegretol and Valproic Acid levels revealed the following: Depakene: 1/12/08 - 41.7 mcg/ml (normal range: 50 - 100 mcg/ml. A nursing note reflected that the primary care physician was notified on 1/22/08. Depakene: 5/31/08 - 21.0 mcg/ml. There was no evidence that the Depakene level was monitored every three months as prescribed. Tegretol: 5/31/08 - 5 mcg/ml (normal range: 4 - 12mcg/ml) Thru interview with the LPN on July 31, 2008 and the record review it was determined that the PCP was routinely telephoned to inform him of the results of lab tests. The LPN also indicated that the PCP made monthly visits to monitor the client and was accompanied by the Director of Nursing. Review of progress notes dated April 10, 2008, May 3, 2008 , and June 21, 2008 reflected that the client was stable and had no new problems. The June 21, 2008 medical review noted that the client's last seizure was in December 2006. There was no evidence that the PCP was aware of the client seizure activity which began on April 11, 2008. The facility failed to ensure Resident #6's seizure management protocol which required timely monitored of abnormal anticonvulsant levels and seizure activity was implemented. 2. The facility's nursing staff failed to consistently document Resident #4's sleep.	I 401		

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I 401	Continued From page 4 Cross-refer to W120. On July 30, 2008, Resident #4 was observed sleeping and/or showing signs of lethargy at his day program. His direct support staff indicated that this was routine behavior. In the residence later that day, at approximately 4:30 PM, the evening LPN stated that overnight nurses were expected to document the client ' s sleep pattern in their " Nurse 24-Hour Report. " At 4:39 PM, review of that log book for the period June 16, 2008 - July 29, 2008 revealed that overnight nurses failed to document the client ' s sleep on 22 of the 44 nights (June 17, 18, 21, 22, 23, 25, 26 and July 1, 3, 5, 13, 14, 15, 16, 17, 20, 21, 23, 24, 26, 27 and 28, 2008). This is a repeat deficiency. In the April 25, 2008 survey, day program direct support staff had questioned whether the client was sleeping through the night, because he slept through much of the day. The day program nurse had also indicated that the client was drowsy and/or slept often. The QMRP stated that the nurses were responsible for documenting the client ' s sleep pattern. The April 25, 2008 survey, however, revealed that overnight nurses had not been consistently documenting his sleep pattern. The facility ' s May 30, 2008 Plan of Correction included the following: " Residential LPN will maintain regular contact with the day program nurse ... LPN/RN will continue to conduct routine visits to the day program, conduct observations and address concerns as they arise. " Interviews with day program and residential nurses on July 30, 2008 revealed that to date, there had been no observation visits by residential nurses to the day program since the April survey. In addition, residential nurses were previously unaware that Resident #4 displayed frequent sleeping behavior while at the day program.	I 401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2008
NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		

(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) COMPLETE DATE
I 401	Continued From page 6 notified of the ER visit or recommendation for health care follow-up in 2 - 3 days. There was no evidence the the client received nursing and medical services in accordance with his needs. 5. The review of an unusual incident report dated June 17, 2008 revealed that Resident #5 was observed to have a 1 cm open area on his right great toe. The incident report documented that the day nurse was notified and would schedule a appointment. The corresponding nursing progress note dated June 17, 2008 (8:00 AM) revealed the client had no sign of infection. Further review of the nursing progress notes failed to provide documentation reflecting monitoring of the open area on the client right great toe again until June 19, 2008. There was no evidence the client was monitored closely by the nurse after his injury of unknown origin to his right great toe. Interview with the nurse on July 31, 2008 at 1:35 PM revealed a podiatry appointment was scheduled for June 23, 2008. The review of a podiatry progress dated June 23, 2008 revealed dried blood on dorsal 4th toe right foot and first toe right foot. Neosporin Cream was prescribed to be applied to both toes for three weeks.	I 401		