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	HFD03-0044	A. BUILDING _____ B. WING _____	04/26/2019

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COMMUNITY MULTI SERVICES, INC	5610 FIRST STREET NW WASHINGTON, DC 20011

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I 000	INITIAL COMMENTS A licensure survey was conducted from 04/23/19 to 04/26/19. Two residents were selected from a population of two men with various degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and review of client and administrative records. The following abbreviations will appear throughout the report: CT - Computerized Tomography DON - Director of Nursing DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities ISP - Individual Support Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg-milligram OT - Occupational Therapist PCP - Primary Care Physician POS - Physician Order Sheet QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse SLP - Speech Language Pathologist TME - Trained Medication Employee	I 000		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by:	I 056		

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I 056	Continued From page 1 Based on observation and interview, the GHIID failed to ensure each staff was effectively trained on food handling practices to meet the needs of two of the two residents in the sample (Residents #1 and 2). Finding included: On 04/25/19 at 12:13 PM, an observation of the food preparation area was conducted by the QIDP and the surveyor. There was an accumulation of grease on the exterior of food storage containers on the countertop. There was a scoop stored in the flour container which was used to remove the flour. The storage of the scoop inside the flour created the potential for cross-contamination. Also, none of the food containers on the counter were labeled. Interview with the QIDP on 04/25/19 at 12:36 PM revealed that some of the staff were certified food handlers and were trained on food storage. The review of the staff training confirmed that seven staff in the facility were trained. At the time of the survey, the GHIID failed to ensure each staff demonstrated safe food handling practices at all times.	I 056	All staff in the facility will be trained as certified food handlers. QIDP will monitor weekly for proper storage and cleanliness of the facility.	6/21/19
I 090	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 accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by:	I 090		

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I 090	Continued From page 2 Based on observation and interview, the GHIID failed to ensure the environment was maintained in accordance with the needs of two of two residents in the sample (Residents #1 and 2). Findings included: On 04/25/19 beginning at 11:51 PM, the QIDP, and the surveyor observed the following: A. The dishwasher detergent dispenser lid was missing from the door. The missing door prevented the detergent from being dispensed at the appropriate time in the dishwashing cycle. B. The back door (adjacent to the bathroom) was obstructed by the pipes on the hot water heater. This created the potential for damaging the pipes if the door was slammed. C. The plastic vegetable storage bin in the bottom of the refrigerator was broken. The broken edge created the potential for injury. D. There was no thermometer in the freezer located in the basement to monitor food temperatures. At the time of the observations, the QIDP stated that the concerns would be communicated to the program director.	I 090	Dishwasher detergent dispenser lid was replaced. Basement back door stopper installed to prevent damage to pipes. Plastic vegetable storage bin replaced. The thermometer was replaced in basement freezer.	5/11/19 5/29/19 5/29/19 5/29/19
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.	I 180		

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I 180	Continued From page 3 This Statute is not met as evidenced by: Based on observation, interview and record review, the QIDP failed to: (I) monitor implementation of the mealtime protocol at the residential GHIID, and (II) monitor and coordinate the mealtime protocol at the day program, for one of two residents in the sample (Resident #1). Findings included: I. On 04/23/19 at 7:23 AM, Resident #1 was observed wearing a large clothing protector and using a plate guard during breakfast. A few minutes later the resident ate the meal independently with a tablespoon. He rapidly drank milk and water from a large glass (approximately 12-ounce size), and spilled a large amount onto the clothing protector. A subsequent observation on 04/24/19 showed the resident eating in the same manner. Resident #1's feeding protocol dated 09/16/18 included instructions to allow one to two teaspoons per swallow to reduce overstuffing of mouth. Provide one half (1/2) cup or glass of liquids at a time to reduce the fast rate of intake and gulping behavior. On 04/25/19 at 4:40 PM, the QIDP stated that Resident #1 should always eat with a teaspoon. He should be prompted to prevent gulping of beverages. At the time of the survey, the QIDP failed to monitor the implementation of the mealtime protocol at the residential GHIID. II. On 04/25/19 at 4:25 PM, the QIDP stated that Resident #1 was prescribed a plate-guard and food protector several years ago. He verbalized	I 180	QIDP will retrain staff on Client #1 mealtime protocol. QIDP will monitor weekly for proper use of adaptive equipment to include drinking cup, plate guard and clothing protector.	5/29/19

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I 180	Continued From page 4 visits to Resident #1's day program, usually during the morning drop-off and afternoon pickup times. He stated the day program was provided the resident's feeding protocol which included the plate guard and clothing protector. The QIDP reported that several weeks before the survey, the day program sent a verbal message by the support staff about Resident #1's spillage of liquids. He further stated that on 04/25/19 he emailed the SLP to request an evaluation of the resident's drinking skills. According to the day program first quarterly report, dated 01/29/19, Resident #1's adaptive equipment plate guard is used appropriately. He has to be prompted to slow his rate of eating, and especially his drink which he will drink quickly, saturating his clothing. There was no mention of a clothing protector. At the time of the survey, the QIDP failed to coordinate the availability of the resident's plate guard, drinking cup and protective cover for use at the day program.	I 180	QIDP delivered adaptive equipment to day program to include plate guard, drinking cup and clothing protector. 5/29/19	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to train each staff to report injuries to appropriate health care professionals after a head injury, for one of two residents in the sample (Resident #1). Findings included:	I 222		

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I 222	Continued From page 5 The GHIID failed to ensure Resident #1's left forehead injury was reported to the DON when it occurred as required: On 4/23/19 at 7:42 AM, there was a quarter-size dark red area with a scab on Resident #1's left forehead. Also, several red scratches were on the resident's left lower leg. When asked how the resident got the injuries, DSP #2 said: "It happened on Sunday, 04/21/19". On 4/24/19 at 12:45 PM, the DON stated staff did not inform her of the resident's injury until the 4/22/19. The DON also stated that staff is required to notify the DON/RN immediately when a resident is injured. Record review revealed the following details concerning Resident # 1's injury and treatments received after the injury. a. On 04/23/19, at 2:47 PM, review of an unusual incident report dated 04/21/19 showed that at 12:00 PM, Resident #2 stepped in a puddle of water and stumbled, while at the church Easter Egg Hunt. He struck his forehead on the wall of the building, suffering an abrasion to the left side of his head. The resident was taken home immediately by agency transportation. The medication nurse (LPN #1) evaluated him. b. Review of the Health Concern Form dated 04/21/19, showed DSP #3 witnessed Resident #1's injury at 12:00 PM. Upon returning to the home, DSP #3 completed the form. It requires staff to immediately notify the supervisory staff if there is an injury. The form noted that no supervisory staff was informed (RN, LPN, RN on call, QIDP, or residential director). On 04/21/19 at 5:00 PM, the medication nurse (LPN #1) assessed and treated Resident #1's injuries.	I 222	The facility's RN provided training to DSP#2 on reporting incidents involving medical injuries. DSP#2 will be monitored for compliance by QIDP and RN. 4/29/19 DSP#2 received disciplinary action for not following Policy and Procedures for reporting incidents. 5/13/19	

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I 222	Continued From page 6 c. An LPN #1 (medication nurse) progress note dated 04/21/19 at 5:00 PM documented Resident #1 sustained an abrasion to his lower left leg and to his left side of scalp/forehead. The injuries were superficial. There was no bleeding or swelling observed at that time. The progress note did not state whether the DON/RN was notified of the resident's injury. On April 22, 2019, at 8:30 AM, LPN #2 (medication nurse) wrote that she observed the resident with a moderate size bruise to the anterior front left forehead, scabbing, but not bleeding. d. The RN nursing progress note dated 04/24/19 documented that staff reported that Resident #1 had an abrasion to his left forehead. The RN cleaned and treated the area, and texted the PCP to notify of the incident. The nurse reinstructed the staff on safety and fall precautions. Monitor the resident and notify the RN for any observed changes. e. The PCP observed Resident #1's injury to the left forehead and left leg on 4/24/19 at 3:38 PM. He stated that the resident appeared to be fine; however, he would send the resident for a CT scan as soon as possible. During the interim, the nurse should continue to treat the injury and monitor him for any changes. The RN presented a prescription dated 04/26/19 for a CT of the head without contrast. On 04/25/19 at 4:50 PM, the review of a training form dated 04/25/19 showed that the RN retrained DSP #3 to report all injuries, including falls, with or without injury. Further discussion with the RN revealed that she also retrained LPN #1 on immediate reporting of injuries to the nursing supervisor when discovered. The documentation of LPN #1 retraining was	I 222	The LPN#1 received additional training by DON on the importance of reporting all injuries and to continue to provide treatment and monitoring until injury resolved. DON will monitor for compliance.	5/29/19

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I 222	Continued From page 7 requested but was not provided before the survey exit. At the time of the survey, the GHIID failed to report a resident's injuries to the nursing supervisor to obtain instructions.	I 222		
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 GHIID failed to monitor blood pressure as prescribed for one of two residents in the sample (Resident #1). Findings included: On 04/23/19 at 8:32 AM, Resident #1 received morning medications from LPN #2, which included Amlodipine 10 mg tablet and Atenolol 100 mg tablet. LPN #2 stated that the medication was prescribed to control hypertension, and blood pressure was monitored and documented on Mondays and Thursdays. On 04/23/19 at 9:43 AM, a POS dated 04/01/19 included Atenolol 100 mg tablet and Amlodipine 10 mg tablet in the morning for hypertension. Additionally, the POS stated to monitor blood pressure on Mondays and Thursdays. Notify the PCP if blood pressure is greater than 160/100 in	I 401	The facility's RN has retrained the TME on vital sign assessments as ordered by PCP. Monitoring for compliance will be completed by RN.	5/29/19

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I 401	Continued From page 8 two consecutive readings. The MAR noted the blood pressure was to be checked and documented at 8:00 AM on Mondays and Thursdays. On Thursday, 04/25/19 at starting at 8:00 AM, TME #1 gave Resident #2 Amlodipine 10 mg tablet and Atenolol 100 mg tablet. The TME did not assess the resident's blood pressure. Review of Resident #1's MAR on 04/26/19 at 9:10 AM, showed no blood pressure was documented for Resident #1 on Thursday, 04/25/19. When asked, TME #1 confirmed that he did not check Resident #1's blood pressure on Thursday. At the time of the survey, the GHIID failed to ensure monitoring of Resident #1's blood pressure as prescribed by the PCP.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure the day program implemented the feeding protocol in accordance with the ISP for one of two clients in the sample (Resident #1). Findings included: Resident #1 was observed at the day program eating lunch on 04/23/19 at 12:41 PM. He ate from a regular plate with a teaspoon. The resident drank milk and water from 4-ounce cups rapidly	I 422		

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I 422	Continued From page 9 which spilled onto his shirt. When asked about the resident's self-feeding skills, the support staff stated Resident #1 was able to eat independently and used no adaptive equipment. However, he suggested an adaptive cup to decrease the spillage of liquids. The support staff stated that Resident #1 had been on his caseload for about one month. Resident #1's feeding protocol dated 09/16/18, reviewed on 04/23/19 showed the resident drinks consecutive swallows, gulps his liquids and is an aspiration risk. Avoid consecutive swallowing for swallow safety and to reduce spillage. Use a plate guard to minimize spillage during meals. Allow one to two teaspoons per swallow to reduce overstuffing. Provide one half (1/2) cup or glass of liquids at a time to reduce the fast rate of intake and gulping behavior. The resident has a protective cover. On 04/24/19 at 1:30 PM, review of Resident #1's ISP dated 09/18/18 revealed the interdisciplinary team approved to continue the use of a plate guard and a protective cover when eating. At the time of the survey, the GHIID failed to ensure that the day program had a client's prescribed adaptive equipment.	I 422	Adaptive equipment for Client #1 was delivered to day program to include plate guard, drinking cup and clothing protectors.	5/29/19

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E 000	Initial Comments An emergency preparedness survey was conducted from 04/23/19 through 04/26/19. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. Direct Support Professional EPP - Emergency Preparedness Program QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037	DSP #4 will receive training on the EPP by the QIDP. QIDP will retrain all employees annually and review EPP Training records quarterly to ensure training for new and senior employees. 6/6/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 5/30/19

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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arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency

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preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each staff (one of nine staff, DSP #4) was trained on the facility's emergency procedures for two of the two clients in the sample (Clients #1 and 2). Findings included: On 04/26/19 at 7:37 AM, DSP #4 said during an interview that he had received the facility's Fire	E 037		

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	09G139	A. BUILDING _____ B. WING _____	04/26/2019

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E 037	Continued From page 4 Emergency Drill training. Further discussion with DSP #4 that he did not receive official training on the facility's EPP since he began employment at the facility in May 2018. When interviewed on 04/26/19 at 9:53 AM, the QIDP confirmed that the facility had not trained DSP #4 on the EPP after employment at the facility. The QIDP stated that the EPP required that all employees be trained. At 10:15 AM, review of the facility's training policy dated 11/24/18 revealed that each staff will receive a series of training, including preparing for emergency contingencies. At the time of the survey, there was no documented evidence that DSP #4 received initial training on the facility's EPP.	E 037		

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W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from 04/23/19 to 04/26/19. Two clients were selected from a population of two men with various degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process.

The findings of the survey were based on observations, interviews and review of client and administrative records.

The following abbreviations will appear throughout the report:

CT - Computerized Tomography
DON - Director of Nursing
DSP - Direct Support Professional
ISP - Individual Support Plan
LPN - Licensed Practical Nurse
MAR - Medication Administration Record
mg-milligram
OT - Occupational Therapist
PCP - Primary Care Physician
POS - Physician Order Sheet
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse
SLP - Speech Language Pathologist
TME - Trained Medication Employee

W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3)	W 120		

The facility must assure that outside services meet the needs of each client.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	5/30/19

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 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the day program implemented the feeding protocol accurately for one of two clients in the sample (Client #1). Findings included: Client #1 was observed at the day program eating lunch on 04/23/19 at 12:41 PM. He ate from a regular plate with a teaspoon. The client drank milk and water from 4-ounce cups rapidly which spilled onto his shirt. When asked about the client's self-feeding skills, the support staff stated Client #1 was able to eat independently and used no adaptive equipment. However, he suggested an adaptive cup to decrease the spillage of liquids. The support staff stated that Client #1 had been on his caseload for about one month. Client #1's feeding protocol (dated 09/16/18), reviewed on 04/23/19 showed the client drinks consecutive swallows, gulps his liquids and is an aspiration risk. Avoid consecutive swallowing for swallow safety and to reduce spillage. Use a plate guard to minimize spillage during meals. Allow one to two teaspoons per swallow to reduce overstuffing. Provide one half (1/2) cup or glass of liquids at a time to reduce the fast rate of intake and gulping behavior. The client has a protective cover. At the time of the survey, the facility failed to ensure that the day program had a client's prescribed adaptive equipment.	W 120	The adaptive equipment (sippy cup, clothing protector and plate guard) have been ordered, received and delivered to day program. QIDP will monitor the day program bi-monthly and residential facility weekly to ensure the feeding protocol is properly implemented including use of adaptive equipment for Client #1.	5/29/19 5/29/19
W 159	QIDP CFR(s): 483.430(a)	W 159		

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W 159	Continued From page 2	W 159		

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the QIDP failed to: (I) monitor implementation of the mealtime protocol at the residential facility, and (II) monitor and coordinate the mealtime protocol at the day program, for one of two clients in the sample (Client #1).

Findings included:

I. On 04/23/19 at 7:23 AM, Client #1 was observed wearing a large clothing protector and using a plate guard during breakfast. A few minutes later the client ate the meal independently with a tablespoon. He rapidly drank milk and water from a large glass (approximately 12-ounce size), and spilled a large amount onto the clothing protector. A subsequent observation on 04/24/19 showed the client eating in the same manner.

Client #1's feeding protocol dated 09/16/18 included instructions to allow one to two teaspoons per swallow to reduce overstuffing of mouth. Provide one half (1/2) cup or glass of liquids at a time to reduce the fast rate of intake and gulping behavior.

On 04/25/19 at 4:40 PM, the QIDP stated that Client #1 should always eat with a teaspoon. He should be prompted to prevent gulping of beverages.

At the time of the survey, the QIDP failed to monitor the implementation of the mealtime

QIDP will provide continuous monitoring of mealtime protocol for Client #1 to observe for proper use of adaptive equipment to include plate guard, drinking cup and clothing protector. 5/29/19

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W 159	Continued From page 3 protocol at the residential facility. II. On 04/25/19 at 4:25 PM, the QIDP stated that Client #1 was prescribed a plate-guard and food protector several years ago. He verbalized visits to Client #1's day program, usually during the morning drop-off and afternoon pickup times. He stated the day program was provided the client's feeding protocol which included the plate guard and clothing protector. The QIDP reported that several weeks before the survey, the day program sent a verbal message by the support staff about Client #1's spillage of liquids. He further stated that on 04/25/19 he emailed the SLP to request an evaluation of the client's drinking skills. According to the day program first quarterly report, dated 01/29/19, Client #1's adaptive equipment plate guard is used appropriately. He has to be prompted to slow his rate of eating, and especially his drink which he will drink quickly, saturating his clothing. There was no mention of a clothing protector. At the time of the survey, the QIDP failed to coordinate the availability of the client's plate guard, drinking cup and protective cover for use at the day program.	W 159	QIDP delivered the adaptive equipment to the day program which included the plate guard, drinking cup and clothing protector for Client #1.	5/29/19
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) 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:	W 192		

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W 192	Continued From page 4 Based on interview and record review, the facility failed to train each staff to report injuries to appropriate health care professionals after a head injury, for one of two clients in the sample (Client #1). Findings included: The facility failed to ensure Client #1's left forehead injury was reported to the DON when it occurred as required: On 4/23/19 at 7:42 AM, there was a quarter-size dark red area with a scab on Client #1's left forehead. Also, several red scratches were on the client's left lower leg. When asked how the resident got the injuries, DSP #2 said: "It happened on Sunday, 04/21/19". On 4/24/19 at 12:45 PM, the DON stated staff did not inform her of the client's injury until the 4/22/19. The DON also stated that staff is required to notify the DON/RN immediately when a client is injured. Record review revealed the following details concerning Client # 1's injury and treatments received after the injury. a. On 04/23/19, at 2:47 PM, review of an unusual incident report dated 04/21/19 showed that at 12:00 PM, Client #2 stepped in a puddle of water and stumbled, while at the church Easter Egg Hunt. He struck his forehead on the wall of the building, suffering an abrasion to the left side of his head. The client was taken home immediately by agency transportation. The medication nurse (LPN #1) evaluated him. b. Review of the Health Concern Form dated 04/21/19 showed DSP #3 witnessed Client #1's	W 192	The facility's RN provided training to DSP#2 on reporting incidents involving medical injuries. DSP#2 will be monitored for compliance by QIDP and RN. 4/25/19 DSP#2 received disciplinary action for not following Policy and Procedures for reporting incidents. 5/13/19	

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W 192	Continued From page 5	W 192		

injury at 12:00 PM. Upon returning to the home, DSP #3 completed the form. It requires staff to immediately notify the supervisory staff if there is an injury. The form noted that no supervisory staff was informed (RN, LPN, RN on call, QIDP, or residential director). On 04/21/19 at 5:00 PM, the medication nurse (LPN #1) assessed and treated Client #1's injuries.

c. The LPN #1 (medication nurse) progress note dated 04/21/19 at 5:00 PM documented Client #1 sustained an abrasion to his lower left leg and to his left side of scalp/forehead. The injuries were superficial. There was no bleeding or swelling observed at that time. The progress note did not state whether the DON/RN was notified of the client's injury. On April 22, 2019, at 8:30 AM, LPN #2 (medication nurse) wrote that she observed the resident with a moderate size bruise to the anterior front left forehead, scabbing, but not bleeding.

d. The RN nursing progress note dated 04/24/19 documented that staff reported that Client #1 had an abrasion to his left forehead. The RN cleaned and treated the area, and sent a text to the PCP of the incident. The nurse re-instructed the staff on safety and fall precautions. Monitor the client and notify the RN for any observed changes.

e. The PCP observed Client #1's injury to the left forehead and left leg on 4/24/19 at 3:38 PM. He stated that the client appeared to be fine; however, he would send the client for a CT scan as soon as possible. During the interim, the nurse should continue to treat the injury and monitor him for any changes. The RN presented a prescription dated 04/26/19 for a CT of the head without contrast.

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W 192	Continued From page 6 On 04/25/19 at 4:50 PM, the review of a training form dated 04/25/19 showed that the RN retrained DSP #3 to report all injuries, including falls, with or without injury. Further discussion with the RN revealed that she also retrained LPN #1 on immediate reporting of injuries to the nursing supervisor when discovered. The documentation of LPN #1 retraining was requested but was not provided before the survey exit. At the time of the survey, the facility failed to report a client's injuries to the nursing supervisor to obtain instructions.	W 192	The LPN#1 will receive additional training by DON on the importance of reporting all injuries and to continue to provide treatment and monitor injury until resolved. DON will monitor for compliance.	5/29/19
W 331	NURSING SERVICES CFR(s): 483.460(c) 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 monitor blood pressure as prescribed for one of two clients in the sample (Client #1). Findings included: On 04/23/19 at 8:32 AM, Client #1 received morning medications from LPN #2, which included Amlodipine 10 mg tablet and Atenolol 100 mg tablet. LPN #2 stated that the medication was prescribed to control hypertension, and blood pressure was monitored and documented on Mondays and Thursdays.	W 331	The facility's RN will retrain the TME on vital signs assessments as ordered by PCP. Monitoring for compliance will be completed by RN.	5/29/19

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W 331	Continued From page 7 On 04/23/19 at 9:43 AM, a POS dated 04/01/19 included Atenolol 100 mg tablet and Amlodipine 10 mg tablet in the morning for hypertension. Additionally, the POS stated to monitor blood pressure on Mondays and Thursdays. Notify the PCP if blood pressure is greater than 160/100 in two consecutive readings. The MAR noted the blood pressure was to be checked and documented at 8:00 AM on Mondays and Thursdays. On Thursday, 04/25/19 starting at 8:00 AM, TME #1 gave Client #2 Amlodipine 10 mg tablet and Atenolol 100 mg tablet. The TME did not assess the client's blood pressure. Review of Client #1's MAR on 04/26/19 at 9:10 AM, showed no blood pressure was documented for Client #1 on Thursday, 04/25/19. When asked, TME #1 confirmed that he did not check Client #1's blood pressure on Thursday. At the time of the survey, the facility nursing staff failed to ensure monitoring of Client #1's blood pressure as prescribed by the PCP.	W 331		