STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING _____ B. WING _____	10/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(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 recertification survey was conducted from 10/28/2010 through 10/29/2010. A sample of two clients was selected from a population of four men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of health care services, the process was extended on 10/29/2010 to review the facility's level of compliance in the Condition of Participation (CoP) for Health Care Services. The findings of the survey were based on observations and 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	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 11-19-10	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients in the sample. [Client #2]	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dr. Rodwell Bacchus	Administrator	11/16/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 The finding includes: On 10/28/2010, at 7:40 a.m., Client #2 was observed receiving Zyprexa 5 mg and Tegretol 200 mg. A short time later, at 8:27 a.m., the qualified mental retardation professional (QMRP) stated that all four residents received psychotropic medications. On 10/29/2010, at approximately 11:30 a.m., review of Client #2's medical records revealed a telephone order dated 4/15/2010, to discontinue Tegretol 150 mg twice a day and to begin Tegretol 200 mg 1 tab in the morning and 2 tabs (400 mg) at night. This effectively doubled his daily dose of Tegretol. At 2:00 p.m., review of Client #2's Psychological Assessment, dated 5/5/2010, revealed a section entitled "Competency in Decision Making." According to that section, he "does not evidence the capacity to make decisions on his own behalf in treatment/habilitation, ongoing medical care, residential/placement, and financial matters." Interview with the licensed practical nurse (LPN) on 10/29/2010, at approximately 3:36 p.m., confirmed that Client #2's Tegretol was increased due to an increase in his maladaptive behaviors. When asked if the client's guardian had been informed of the medication increase, the LPN directed this surveyor to the QMRP. At approximately 4:30 p.m. on the same day, interview with the QMRP revealed that the facility had implemented the increase in Tegretol even though the client's guardian had not signed and returned a consent form. There was no evidence that Client #2's treatment needs, including the benefits and potential side	W 124	**W 124** **The facility shall put in place a tracking system to ensure that all restricted controls are consented to by guardians/family members before implementation.** **Client # 2's family has signed the consent form for the increase in Tegretol.**	11/29/10

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W 124	Continued From page 2 effects associated with the medications, and the right to refuse treatment, including the increase in Tegretol, had been explained to the client's guardian.	W 124		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consent, for one of the two clients in the sample. [Client #2] The finding includes: Cross-refer to W124. The facility's human rights committee failed to ensure that informed consent had been obtained from Client #2's court-appointed medical guardian prior to the increase of the client's Tegretol.	W 263	**W 263** **Please refer to W 124.**	
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's medical team failed to ensure consistent and effective services for the management of diabetes, for the one client in the	W 322		

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W 322	Continued From page 3 sample who was diagnosed with insulin-dependent diabetes mellitus. [Client #1] The findings include: Cross-refer to W331. The facility's nursing staff failed to: 1. ensure accurate transcription of Client #1's physician's orders; 2. ensure that a Registered Nurse (RN) reviewed clients' POs; 3. document administration of Novolog insulin in accordance with Client #1's POs; and, 4. failed to document the time they performed Client #1's blood glucose testing. Interviews and record review on 10/29/2010 revealed no evidence that the client's primary care physician identified the deficient practices in the 9 months since Client #1's insulin was first prescribed on 1/7/2010.	W 322	**W 322: 1, 2, 3, 4** **The facility's Registered Nurse (RN) will train the Licensed Practical Nurses (LPNs) on issues of: transcription of physician's orders; adhering to Physician's Orders (POs) in relation to timely administration of Novolog insulin, and accurate documentation of the time blood glucose testing is to be done.** **A form will be put in place capturing the above-mentioned indicators.** **The facility's RN will on a monthly basis review medical records including POs to ensure compliance with orders.**	11/29/10
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 clients received nursing services according to their needs, for one of the two clients in the sample. [Client #1] The findings include:	W 331		

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W 331	Continued From page 4 1. The facility's nursing staff failed to ensure accurate transcription of Client #1's physician's orders, as follows: On 10/28/2010, at 7:11 a.m., Client #1 was observed eating breakfast. At 7:29 a.m., the facility's nurse (LPN) arrived to administer medications. At 7:52 a.m., the LPN stated that he would perform a finger stick for Client #1 "so that he can eat." A direct support staff person informed him that the client had already eaten breakfast. His response was "ok" and he proceeded to prepare the client's medications. He performed the finger stick at 8:07 a.m. a. At 9:28 a.m., review of the client's 9/2010 physician's orders (POs) confirmed that the client was diagnosed with insulin-dependent diabetes mellitus. Continued review of the POs revealed that the order for finger sticks read "twice daily." The POs did not, however, indicate the times of day to administer the finger sticks. On 10/29/2010, at 11:58 a.m. review of POs revealed that the initial order, dated 1/7/2010, was to "check finger stick in the morning before meal and at bedtime." The 9/2010 and 10/2010 POs, therefore, did not accurately reflect what had been ordered. b. On 10/29/2010, at 11:58 a.m. review of POs revealed that the initial order, dated 1/7/2010, was to "check finger stick in the morning before meal and at bedtime." Review of the POs for 2/2010 and the 8 months that followed revealed that the pharmacist had typed "finger sticks once daily." The LPN had drawn a line through the word "once" on the 2/2010 POs and wrote "twice." The POs for 3/2010 through 8/2020, however, all still read "once daily." At approximately 1:00 p.m., the	W 331	**W 331:1a** **The order for when the finger stick testing is to be done has been clarified with the prescribing physician.** **The facility's RN will in-service the LPNs on adhering to POs especially in relation to timely administration of finger sticks.** **Once monthly, the facility's RN will observe the LPNs when administering finger sticks to ensure compliance with timely administration.**	11/29/10

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W 331	Continued From page 5 LPN acknowledged that the time-specific order for finger sticks ("in the morning before meal and at bedtime") had not been transcribed onto Client #1's POs after the initial telephone order taken on 1/7/2010. [Note: The LPN further acknowledged that the client's blood sugar had not been tested in accordance with the POs. He said the finger sticks routinely had been performed at "approximately 7 a.m. and approximately 6:00 p.m." daily.] c. On 10/29/2010, at approximately 1:05 p.m., the LPN presented a consultation form that documented Client #1's visit to the endocrinologist on 10/25/2010. The form indicated that the endocrinologist recommended a change in timing of the finger sticks. From 1/7/2010 until 10/24/2010, the recommendation had been to perform finger sticks in the morning before meal and at bedtime. On 10/25/2010, however, the endocrinologist recommended "finger sticks 2 hours after meals/bedtime." According to the LPN, he faxed the consultation form to the primary care physician (PCP) on the next day and the PCP initialed the form that day (10/26/2010). The LPN stated that the PCP had concurred with the endocrinologist's recommended change to "finger sticks 2 hours after meals/bedtime." He acknowledged, however, that as of 10/29/2010, Client #1's POs still read "twice daily" and, therefore, did not reflect a new order. During the Exit conference, at 5:33 p.m., the qualified mental retardation professional also stated that it was his understanding that the PCP had agreed to the recommended change in orders. 2. The facility failed to ensure that a Registered Nurse (RN) reviewed clients' POs, as follows:	W 331	**W 331: 1b, 1c** **The order for when the finger stick testing is to be done has been clarified with the prescribing physician.** **The facility's Registered Nurse (RN) will on a quarterly basis train the Licensed Practical Nurses (LPNs) on issues of: transcription of physician's orders; adhering to Physician's Orders (POs) in relation to timely administration of Novolog insulin, and accurate documentation of the time blood glucose testing was completed.**	11/29/10

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W 331	Continued From page 6 On 10/29/2010, beginning at 11:58 a.m., review of Client #1's POs for the period 2/2010 through 9/2010 revealed no evidence that the facility's RN had documented a review (with signature and date) of the POs. The two signatures observed on the POs were those of the LPN and the PCP. 3. The facility's nursing staff failed to document administration of Novolog insulin in accordance with Client #1's POs, as follows: On 10/29/2010, beginning at 11:58 a.m., review of Client #1's POs revealed that beginning on 1/7/2010, he was to receive Lantus 10 units at bedtime every day. In addition, nurses were to "check finger stick in the morning before meal and at bedtime." If a finger stick showed a blood glucose reading above 149, then Novolog insulin was to be administered as follows: 150-199 take 1 unit; 200-249 take 2 units; 250-299 take 3 units; 300-349 take 4 units; and, >349 take 5 units. On 10/29/2010, beginning at approximately 1:25 p.m., review of Client #1's medical chart revealed that his blood glucose readings and the administration of Novolog insulin were being documented on "Fingerstick Blood Glucose Monitoring Record" (FSBGMR) forms (solely). Review of the FSBGMR forms revealed that nurses had documented elevated blood glucose test results 5 times in the month of 9/2010 but failed to document the administration of Novolog insulin on 1 of those 5 occasions (20%). Similarly, nurses failed to document the administration of Novolog on 3 out of 16 times	W 331	**W 331: 2** **The facility's Qualified Mental Retardation Professional (QMRP) will on a monthly basis review the POs with the RN to ensure that all POs are signed by the RN and orders clearly specified.** **W 331: 3** **The facility's RN will in-service the LPNs on accurate documentation of Novolog insulin administration in accordance with the sliding scale. A form has been developed which clearly specifies the sliding scale and amount of Novolog insulin to be administered.** **The facility's RN will on a monthly basis review the Fingerstick Blood Glucose Monitoring Record (FSBGMR) to ensure accurate documentation of Novolog insulin in relation to the sliding scale.**	11/29/10 11/29/10

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W 331	Continued From page 7 (19%) in 10/2010 when glucose readings were elevated [10/1/2010 PM 152; 10/22/2010 PM 226; and, 10/26/2010 PM 164]. During the Exit conference later that day, the qualified mental retardation professional acknowledged that it was unclear whether the client went without the insulin injection or if the client received the medication but the nurse failed to document the administration. 4. The facility's nurses failed to document the time they tested Client #1's blood glucose levels, as follows: On 10/29/10, beginning at approximately 1:25 p.m., review of Client #1's Fingerstick Blood Glucose Monitoring Record forms revealed that from 2/2010 through 10/2010, nurses wrote either "AM" or "PM" for the time they performed the finger stick. They failed to document the exact time that they performed the finger stick and failed to document the exact time if/when they administered Novolog insulin in accordance with the sliding scale prescribed on the client's POs.	W 331	**W 331: 4** **The facility's RN will train the LPNs on accurate documentation of finger stick reading and amount of Novolog insulin to be administered.** **A Medical Administration Record (MAR) will be used to document time insulin was administered, sliding scale unit, and amount of insulin administered.** **The MAR will be reviewed monthly by the RN to ensure accurate documentation**	11/29/10
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 ensure that clients received encouragement and training to utilize	W 436		

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W 436	Continued From page 8 their adaptive equipment as prescribed, for one of the two clients in the sample. [Client #1] The finding includes: Client #1 was observed in the facility on 10/28/2010, from 7:11 a.m. until 8:32 a.m. and from 4:25 p.m. until 4:44 p.m. later that day. The client was not observed wearing eyeglasses that day. On 10/29/2010, at 3:55 p.m., review of Client #1's Individual Support Plan, dated 6/7/2010, revealed that he wore prescription eyeglasses. A direct support staff person, who was present at the time, retrieved the client's eyeglasses from his bedroom. When asked why the glasses were in the bedroom and not with the client (who was at day program), she indicated that there was a problem with how they fit behind his ear. She then directed this surveyor to the nurse (LPN). Moments later, interview with the LPN in the basement revealed a similar description of the concern. The LPN indicated that the client had been seen recently by the ophthalmologist. On 10/29/2010, at approximately 4:00 p.m., review of Client #3's ophthalmology consultation sheet, dated 10/4/2010, revealed diagnoses of glaucoma, corneal edema and aphakia. The ophthalmology report did not, however, indicate there was any problem with eyeglasses. A minute later, the facility's qualified mental retardation professional (QMRP) stated that he was unaware of any concerns with the eyeglasses and the client readily wore them if/when staff provided reminders. On 10/29/2010, at 5:23 p.m., the QMRP stated	W 436		

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W 436	Continued From page 9 that he just gave the client his glasses when he arrived home from day program. Moments later, Client #1 was observed wearing the eyeglasses; he was smiling and did not show any signs of discomfort from them. There was no evidence that facility staff provided Client #1 with encouragement and training to wear his eyeglasses as prescribed.	W 436	**W 436** **An Individual Program Plan (IPP) geared towards enhancing client #1's ability to utilize his eyeglasses efficiently will be put in place.** **Staff will be trained on program implementation.**	11/29/10

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I 000	INITIAL COMMENTS A licensure survey was conducted from 10/28/2010 through 10/29/2010. A sample of two residents was selected from a population of four men with various degrees of intellectual and/or developmental disabilities. The findings of the survey were based on observations and interviews with residents and 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 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: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for four of the four residents in the facility. [Residents #1, #2, #3 and #4] The findings include: Observation and interview with the facility manager (FM) on 10/29/2010, beginning at approximately 10:45 a.m., revealed the following: 1. One of the walls in the closet located in Resident #2's bedroom had a crack in it.	I 090		

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I 090	Continued From page 1 2. One of the walls in the closet located in Resident #1's bedroom also had a crack in it. 3. The front edge of the 3rd step from the top, on the staircase between the main floor and the 2nd floor, was cracked and gave way when stepped upon and body weight was applied. The step presented a potential trip hazard. 4. There was chipped and/or peeling paint on the ceiling of the front porch. The FC acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090	**I 090:1** **The crack in Resident #2's bedroom closet has been repaired.** **I 090:2** **The wall has been repaired.** **I 090:3** **The front edge of the 3rd step has been reinforced.** **I 090: 4** **The ceiling on the front porch will be painted.** **Once monthly, the maintenance division will conduct environmental audits of the exterior and interior of the facility to ensure compliance with standards.**	11/29/10
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to show evidence of a physician's certification that documented a health inventory had been performed for 1 out of 11 professional consultants. The finding includes: On 10/29/2010, at 11:15 a.m., the qualified mental retardation professional presented	I 206		

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I 206	Continued From page 2 personnel records for all employees and consultants. At approximately 12:30 p.m., review of the personnel records revealed no evidence of a current health certificate for the GHMRP's consulting speech pathologist. No additional information was presented before the survey ended later that day.	I 206	**I 206** **The speech and language pathologist has submitted a current health certificate.** **The Administrative Assistant will on a monthly basis review all personnel records and those of the consultants to ensure that all required documents are current and updated in a timely manner.**	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that nursing staff were effectively trained on the management of diabetes, for the one resident in the sample who was diagnosed with insulin-dependent diabetes mellitus. [Resident #1] The findings include: Cross-reference to I291 and I293. The facility's nursing staff failed to ensure accurate transcription of Resident #1's physician's orders, ensure that a Registered Nurse (RN) reviewed residents' POs, document administration of Novolog insulin in accordance with Resident #1's POs and failed to document the time they performed Resident #1's blood glucose testing.	I 229		11/15/10

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I 229	Continued From page 3 On 10/29/2010, at 8:10 p.m., the QMRP presented documentation of an in-service training that the GHMRP's RN provided for the LPNs on the management of Resident #1's diabetes. The documents were dated 6/13/2010. However, observations on 10/28/2010 as well as deficiency practices identified through the review of Resident #1's records (for 9/2010 and 10/2010) on the following day revealed that the nurses' training had not been effective. At 8:17 p.m., the QMRP stated that there had been no additional nurse training provided since 6/13/2010.	I 229	**I 229** **The LPNs will be re-trained by the RN on diabetes management. Such training shall be done quarterly to ensure efficiency in managing client #1's diabetes.**	11/29/10
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to maintain accurate records for one of the two residents in the sample. [Resident #1] The findings include: 1. The GHMRP's nursing staff failed to ensure accurate transcription of Resident #1's physician's orders, as follows: On 10/28/2010, at 7:11 a.m., Resident #1 was observed eating breakfast. At 7:29 a.m., the facility's nurse (LPN) arrived to administer medications. At 7:52 a.m., the LPN stated that he would perform a finger stick for Resident #1 "so that he can eat." A direct support staff person informed him that the resident had already eaten breakfast. His response was "ok" and he	I 291		

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I 291	Continued From page 4 proceeded to prepare the resident's medications. He performed the finger stick at 8:07 a.m. a. At 9:28 a.m., review of the resident's 9/2010 physician's orders (POs) confirmed that the resident was diagnosed with insulin-dependent diabetes mellitus. Continued review of the POs revealed that the order for finger sticks read "twice daily." The POs did not, however, indicate the times of day to administer the finger sticks. On 10/29/2010, at 11:58 a.m. review of POs revealed that the initial order, dated 1/7/2010, was to "check finger stick in the morning before meal and at bedtime." The 9/2010 and 10/2010 POs, therefore, did not accurately reflect what had been ordered. b. On 10/29/2010, at 11:58 a.m. review of POs revealed that the initial order, dated 1/7/2010, was to "check finger stick in the morning before meal and at bedtime." Review of the POs for 2/2010 and the 8 months that followed revealed that the pharmacist had typed "finger sticks once daily." The LPN had drawn a line through the word "once" on the 2/2010 POs and wrote "twice." The POs for 3/2010 through 8/2020, however, all still read "once daily." At approximately 1:00 p.m., the LPN acknowledged that the time-specific order for finger sticks ("in the morning before meal and at bedtime") had not been transcribed onto Resident #1's POs after the initial telephone order taken on 1/7/2010. [Note: The LPN further acknowledged that the resident's blood sugar had not been tested in accordance with the POs. He said the finger sticks routinely had been performed at "approximately 7 a.m. and approximately 6:00 p.m." daily.] c. On 10/29/2010, at approximately 1:05 p.m., the	I 291	**I 291: a, b, c** **The order for when the finger stick testing is to be done has been clarified with the prescribing physician.** **The facility's Registered Nurse (RN) will on a quarterly basis train the Licensed Practical Nurses (LPNs) on issues of: transcription of physician's orders; adhering to Physician's Orders (POs) in relation to timely administration of Novolog insulin, and accurate documentation of the time blood glucose testing was completed.**	11/29/10

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I 291	Continued From page 5 LPN presented a consultation form that documented Resident #1's visit to the endocrinologist on 10/25/2010. The form indicated that the endocrinologist recommended a change in timing of the finger sticks. From 1/7/2010 until 10/24/2010, the recommendation had been to perform finger sticks in the morning before meal and at bedtime. On 10/25/2010, however, the endocrinologist recommended "finger sticks 2 hours after meals/bedtime." According to the LPN, he faxed the consultation form to the primary care physician (PCP) on the next day and the PCP initialed the form that day (10/26/2010). The LPN stated that the PCP had concurred with the endocrinologist's recommended change to "finger sticks 2 hours after meals/bedtime." He acknowledged, however, that as of 10/29/2010, Resident #1's POs still read "twice daily" and, therefore, did not reflect a new order. During the Exit conference, at 5:33 p.m., the qualified mental retardation professional also stated that it was his understanding that the PCP had agreed to the recommended change in orders. 2. The facility's nurses failed to document the time they tested Resident #1's blood glucose levels, as follows: On 10/29/10, beginning at approximately 1:25 p.m., review of Resident #1's Fingerstick Blood Glucose Monitoring Record forms revealed that from 2/2010 through 10/2010, nurses wrote either "AM" or "PM" for the time they performed the finger stick. They failed to document the exact time that they performed the finger stick and failed to document the exact time if/when they administered Novolog insulin in accordance with the sliding scale prescribed on the resident's POs.	I 291	**I 291:2** **The facility's Registered Nurse (RN) will on a quarterly basis train the Licensed Practical Nurses (LPNs) on issues of: transcription of physician's orders; adhering to Physician's Orders (POs) in relation to timely administration of Novolog insulin, and accurate documentation of the time blood glucose testing was completed.**	11/29/10

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I 293	3514.4 RESIDENT RECORDS The record for resident ' s prescribed controlled substances shall be in conformance with § 3522.6 of this chapter. This Statute is not met as evidenced by: Based on interview and record verification, the Group Home for Persons with Mental Retardation (GHMRP) failed to continuously maintain a record of residents' prescribed controlled substances in conformance with § 3522.6 of this chapter, for one of the two residents in the sample. [Resident #1] The findings include: The facility's nursing staff failed to document administration of Novolog insulin in accordance with Resident #1's POs, as follows: On 10/29/2010, beginning at 11:58 a.m., review of Resident #1's POs revealed that beginning on 1/7/2010, he was to receive Lantus 10 units at bedtime every day. In addition, nurses were to "check finger stick in the morning before meal and at bedtime." If a finger stick showed a blood glucose reading above 149, then Novolog insulin was to be administered as follows: 150-199 take 1 unit; 200-249 take 2 units; 250-299 take 3 units; 300-349 take 4 units; and, >349 take 5 units. On 10/29/2010, beginning at approximately 1:25 p.m., review of Resident #1's medical chart revealed that his blood glucose readings and the administration of Novolog insulin were being	I 293		

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I 293	Continued From page 7 documented on "Fingerstick Blood Glucose Monitoring Record" (FSBGMR) forms (solely). Review of the FSBGMR forms revealed that nurses had documented elevated blood glucose test results 5 times in the month of 9/2010 but failed to document the administration of Novolog insulin on 1 of those 5 occasions (20%). Similarly, nurses failed to document the administration of Novolog on 3 out of 16 times (19%) in 10/2010 when glucose readings were elevated [10/1/2010 PM 152; 10/22/2010 PM 226; and, 10/26/2010 PM 164]. During the Exit conference later that day, the qualified mental retardation professional acknowledged that it was unclear whether the resident went without the insulin injection or if the resident received the medication but the nurse failed to document the administration.	I 293	**I 293** **The facility's RN will in-service the LPNs on accurate documentation of Novolog insulin administration in accordance with the sliding scale. A form has been developed which clearly specifies the sliding scale and amount of Novolog insulin to be administered.** **The facility's RN will on a monthly basis review the Fingerstick Blood Glucose Monitoring Record (FSBGMR) to ensure accurate documentation of Novolog insulin in relation to the sliding scale.**	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing	I 379		11/29/10

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I 379	Continued From page 8 Administration (DOH/HRLA), for one of the two residents in the sample. [Resident #1] The finding includes: On 10/29/2010, at approximately 10:40 a.m., review of Resident #1's primary care physician notes revealed that the resident was evaluated in the emergency room on 4/28/2010 following nosebleeds. The incident had not been known previously to DOH/HRLA. During the Exit conference on 10/29/2010, the GHMRP's qualified mental retardation professional (and incident management coordinator) acknowledged that the incident had not been reported to DOH/HRLA. He reported having investigated the nosebleeds and described it as having been an "over reaction" by their staff.	I 379	I 379 **The facility's Incident Management Coordinator (IMC) will on a quarterly basis train staff on incident management policies and procedures.**	11/29/10
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the Group	I 399		

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I 399	Continued From page 9 Home for Persons with Mental Retardation (GHMRP) failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHMRP, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is: Review of the personnel records on 10/29/2010, beginning at 11:15 a.m., revealed that a current license/professional certification was not available for the Speech Language Therapist. At approximately 1:00 p.m., the qualified mental retardation professional confirmed that the license/ professional credentialing for the Speech Language Therapist was not available for review. No additional information was presented before the survey ended later that day. On 11/1/2010, a post-survey search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was currently licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic	I 399	**I 399** **The speech and language pathologist has submitted a current license issued by the District of Columbia.** **The Administrative Assistant will on a monthly basis review all personnel records and those of the consultants to ensure that all required documents are current and updated in a timely manner.**	11/29/10

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I 399	Continued From page 10 medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter.	I 399		
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, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that residents received encouragement and training to utilize their adaptive equipment as prescribed in their Individual Support Plan, for one of the two residents in the sample. [Resident #1] The finding includes: Resident #1 was observed in the facility on 10/28/2010, from 7:11 a.m. until 8:32 a.m. and from 4:25 p.m. until 4:44 p.m. later that day. The resident was not observed wearing eyeglasses that day. On 10/29/2010, at 3:55 p.m., review of Resident #1's Individual Support Plan, dated 6/7/2010, revealed that he wore prescription eyeglasses. A direct support staff person, who was present at	I 422		

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I 422	Continued From page 11 the time, retrieved the resident's eyeglasses from his bedroom. When asked why the glasses were in the bedroom and not with the resident (who was at day program), she indicated that there was a problem with how they fit behind his ear. She then directed this surveyor to the nurse (LPN). Moments later, interview with the LPN in the basement revealed a similar description of the concern. The LPN indicated that the resident had been seen recently by the ophthalmologist. On 10/29/2010, at approximately 4:00 p.m., review of Resident #3's ophthalmology consultation sheet, dated 10/4/2010, revealed diagnoses of glaucoma, corneal edema and aphakia. The ophthalmology report did not, however, indicate there was any problem with eyeglasses. A minute later, the facility's qualified mental retardation professional (QMRP) stated that he was unaware of any concerns with the eyeglasses and the resident readily wore them if/when staff provided reminders. On 10/29/2010, at 5:23 p.m., the QMRP stated that he just gave the resident his glasses when he arrived home from day program. Moments later, Resident #1 was observed wearing the eyeglasses; he was smiling and did not show any signs of discomfort from them. There was no evidence that GHMRP staff provided Resident #1 with encouragement and training to wear his eyeglasses as prescribed.	I 422	**I 422** **An Individual Program Plan (IPP) geared towards enhancing client #1's ability to utilize his eyeglasses efficiently will be put in place.** **Staff will be trained on program implementation.**	11/29/10
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident.	I 474		

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I 474	Continued From page 12 This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP)'s nursing staff failed to maintain medication administration records accurately, for one of the two residents in the sample. [Resident #1] The finding includes: Cross-refer to I293. The GHMRP's nursing staff failed to document administration of Novolog insulin in accordance with Resident #1's physician's orders.	I 474	**I 474** **The facility's Registered Nurse (RN) will on a quarterly basis train the Licensed Practical Nurses (LPNs) on issues of: transcription of physician's orders; adhering to Physician's Orders (POs) in relation to timely administration of Novolog insulin, and accurate documentation of the time blood glucose testing was completed.**	11/29/10