Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	DD0239		C 02/10/2015

NAME OF PROVIDER OR SUPPLIER: SECOND FAMILY, INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 337 BRIGHTSEAT ROAD SUITE 111 LANDOVER, MD 20785

(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
L 000	Initial Comments [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] For all Deficiencies On 10/21/14, 10/29/14, 10/30/14, 11/6/14, 12/1/14, 2/9/15, and 2/10/15 an investigation and follow up was conducted at this facility by the Office of Health Care Quality to investigate one (1) facility reported incident (PCIS28379) and a related complaint (MD00087192) in response to an injury and allegations of possible abuse/neglect of Individual #8330. Survey activities included observations, interviews with staff and advocates, and review of Licensee and hospital medical records, and review of policies, procedures, and other pertinent documentation. The licensee was not found to be in compliance with the Code of Maryland Regulations (COMAR) Title 10, Subtitle 22 Developmental Disabilities Regulations, COMAR Title 14, Subtitle 31 Residential Child Care Program Regulations and COMAR Title 10, Subtitle 27 Nursing Delegation. The following deficiencies are noted.	L 000		
L 374	10.22.02.10A8 P&P-dev& adopt: med administration .10 Policies and Procedures A. A licensee shall develop and adopt written policies and procedures for ensuring: (8) That medications are administered in accordance with the practices established by the Administration's curriculum on medication training;	L 374		

OHCQ

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

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This Regulation is not met as evidenced by:
[Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]

Based on 2/10/15 medical record review, the Licensee failed to ensure accurate transcription of medication orders into the Medication Administration (MAR) record for Individual #2. This was evident for 1/7 Individuals reviewed (Individual #2).
The findings include:
Review of the medical record for Individual #2 on 2/10/15 revealed that one order for
150 mg tab to be given at bedtime was entered into the MAR two times. Staff signed off that the medication was administered two times on 2/1/15, 2/2/15, and 2/3/15 (once in each entry in the MAR). It could not be determined if the resident actually received the medication twice on each of these dates, and Licensee internal systems failed to identify the error for three days. After 2/3/14, the MAR documentation revealed that one of these duplicate orders was noted "DUPLICATE".
Review of the medical record for Individual #2 on 2/10/15 revealed that one order for 25 mg tab to be given by mouth at bedtime was entered into the MAR two times. Staff signed that the medication was administered two times (one in each entry in the MAR) on 2/1/15, 2/2/15, 2/3/15. 2/4/15 and 2/5/15. It could not be determined if the resident actually received the medication twice on each of these dates, and licensee internal systems failed to identify the error for five days. After 2/5/14, the MAR documentation revealed that one of these duplicate orders was then noted "Duplicate".
Review of the medical record for Individual #2 revealed only one order entered on 1/21/15 for Vitamin D. This order was for 400 unit chewable

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L 374	Continued From page 2	L 374		
	tab to be given by mouth daily for 30 days. However, review of the MAR revealed two orders for Vitamin D were entered into the MAR and neither of the two transcriptions were accurate. One transcribed order in the MAR indicated Vitamin D 400 units daily was to be given by mouth but it was "not chewable". This dose was signed out as administered every day from 2/1 through and including 2/9. A second entry in the MAR indicated that another half-tab of Vitamin D 400 International Units was to be given three times a week. This dose was also signed off as administered (on 2/2, 2/4, and 2/6). No order was found in the medical record that was similar to this MAR entry for an additional ½ tab, three times a week. Additionally, another MAR entry indicated that Vitamin D2 1.25 mg (50,000) units) one capsule, was to be given once a week for eight weeks. No corresponding order for this MAR entry was found in the medical record. This vitamin dose was signed off as administered on 2/5/15 and was active in the MAR at the time of the survey on 2/10/15. Also on 2/10/15, the house manager reported that she was going to look into this concern.			
L 515	10.22.02.11.A Staff Req- Staffing Plan	L 515		
	.11 Staffing Requirements.			
	A. Following an analysis of the number of individuals the licensee intends to serve and the needs of each of these individuals being served, the licensee shall develop and implement a staffing plan that adequately addresses the health and safety needs of each individual and provides each individual with the services identified in the IP. The staffing plan may include any person who meets the training requirements of this regulation			

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and who does not have a criminal history as set forth in §B of this regulation. A staff person who meets the above criteria may assume all responsibilities previously assigned to a qualified developmental disabilities professional.

This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]

Based on observations, record review and interviews with staff, the Licensee failed to implement an effective process to ensure current training, certification and licensure for all staff administering medication and/or providing nursing services or delegated nursing functions. These related failures held the potential to affect all Individuals in the home.

Findings Include:

1. Failure to conduct a criminal background check on Staff #18 prior to assigning staff to work with the children the Licensee serves.

During an onsite interview and personnel record review on December 1, 2014 it was determined that no background check had been completed for Staff #18, prior to assignment of independent duties as a Licensed Practical Nurse (LPN).

In accordance with COMAR 10.22.02.03D4(a), on December 1, 2014 the Licensee was issued an "Immediate Notification" of noncompliance with regulatory requirements.

In follow up on 2/10/15, documentation revealed that the background check was completed by 12/15/14.

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2. Failure to verify Maryland Board of Nursing (MBoN) Licensure prior to being assigned independent duties.

Staff interviews and review of pertinent documentation revealed that the licensee did not have an effective process to ensure nursing staff practiced under a license as required by the MBON. At the time of the onsite visit December 1, 2014, the name for Staff #18 did not appear on the MBON web site as currently licensed or certified. Review of the employee personnel file on December 1, 2014 revealed there was no verification that Staff #18 was authorized to practice in the State of Maryland. Review of the MBON online verification site on December 1, 2014 also did not reveal any evidence that Staff #18 was authorized to practice in the State of Maryland. Staff #18 had a name change that was not reflected in the MBON licensure, and lacking an effective verification process, the licensee had no evidence the staff was licensed to practice.

During the February 10, 2015 onsite follow up, 3/19 additional personnel records (Staff #7 CNA, #18 LPN, and #20 LPN) revealed expired license or certification status in the active personnel files. All three held current status with the MBON, but an effective process for verification by the Licensee was still not in place, as evidenced by the three inaccurate personnel files.

In accordance with COMAR 10.22.02.03D4(a), the licensee was issued an "Immediate Notification" of noncompliance with regulatory requirements on December 1, 2014.

This deficiency also applies to Tag Y2205 and Y2230.

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L 530	10.22.02.11.C1 Staff Req-Dev-Train Indep Dut; Adeq Training .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (1) All staff and care providers receive adequate training to perform their assigned duties; This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] The Developmental Disabilities Administration's (DDA) Training Outline Manual indicates that in order to ensure that staff have successfully completed each training, it is the responsibility of the Licensee to test the competency of the staff utilized by the Licensee. Based on observation, record review and staff interviews, the Licensee failed to provide the required DDA training and/or documentation of verified competency/test completion for direct care staff. Findings include: See Tags L545, L560, L565, L570, L575, L580, L590, L600, L605 and L610 for DDA required training deficiencies. Based on staff interview and review of medical records on 2/10/15 review, it was determined that	L 530		

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L 530	Continued From page 6 the Licensee's delegating RN/Supervisor failed to ensure that all staff providing nursing services and delegated nurse functions were trained in process related to Nursing Care Plans (NCPs) for 3 out of 7 Individuals reviewed (#8338, #8339, and #1). Review of the September 2014 Medication Administration Record (MAR) and NCPs on file at the time of the OHCQ onsite visit November 6, 2014 for 3 out of 7 Individuals revealed the following: [Site #|DL7418 Service|GH Individual #|1] On February 10, 2015, Individual #1 had nursing care plans including: 1 A nursing care plan for risk for opened during December 10, 2014, but when reviewed on February 10, 2015 it was only signed off as reviewed by 14/20 staff. In interview the house manager confirmed that all staff need to review the care plans. 2. A nursing care plan for was opened during December 2014, but when reviewed on February 10, 2015 it was only signed off as reviewed by 14/20 staff. In interview the house manager confirmed that all staff need to review the care plans. [Site #|DL7418 Service|GH Individual #|8338] On February 10, 2015, Individual #8338 had nursing care plans including: 1. A nursing care plan for risk for was opened	L 530		

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L 530	Continued From page 7 on December 10, 2014, but when reviewed on February 10, 2015 it was only signed off as reviewed by 5/20 staff. In interview the house manager confirmed that all staff need to review the care plans. 2. A nursing care plan for was opened during November 2014, but when reviewed on February 10, 2015 it was only signed off as reviewed by 7/20 staff. In interview the house manager confirmed that all staff need to review the care plans. [Site #|DL7418 Service|GH Individual #|8339] On February 10, 2015, Individual #8339 had nursing care plans including: 1. A nursing care plan for related to was opened on January 29, 2015, but when reviewed on February 10, 2015 it was only signed off as reviewed by 11/20 staff. In interview the house manager confirmed that all staff need to review the care plans.	L 530		
L 540	10.22.02.11.C2.a Staff Req-Dev-Train Indep Dut; Adm Seiz .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (2) All staff and care providers successfully complete the Administration's approved training to meet the specific needs of the individuals they	L 540		

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L 540	Continued From page 8 serve and to carry out their assigned duties, such as training: (a) Seizure disorders This Regulation is not met as evidenced by: Based on 2/10/15 review of 6 sampled direct care staff training records and interview with licensee's human resources staff, the facility failed to ensure training and competency testing in seizure disorders for 5/6 staff (Staff #1, 2, 3, 4, and 6). The findings include: 2/10/15 staff interview and review of training documentation for 6 sampled staff revealed no required training or competency testing in seizure disorders for staff #1, 2, 3, 4, and 6.	L 540		
L 545	10.22.02.11.C2.b Staff Req-Dev-Train Indep Dut; Adm beha .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (2) All staff and care providers successfully complete the Administration's approved training to meet the specific needs of the individuals they serve and to carry out their assigned duties, such as training: (b) Principles of behavior change This Regulation is not met as evidenced by:	L 545		

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L 545	Continued From page 9 [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 2/10/15 review of 6 sampled direct care staff training records and interview with the licensee's human resources staff, the facility failed to ensure training and competency testing in principles of behavior change for 2/6 staff. The findings include: 2/10/15 staff interview and review of training documentation for 6 sampled staff revealed no required training or competency testing in principles of behavior change for staff #1 and #3.	L 545		
L 550	10.22.02.11.C2.c Staff Req-Dev-Train Indep Dut; Adm app; dis .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (2) All staff and care providers successfully complete the Administration's approved training to meet the specific needs of the individuals they serve and to carry out their assigned duties, such as training: (c) Management of disruptive behaviors, This Regulation is not met as evidenced by: Based on 2/10/15 review of 6 sampled direct care staff training records and interview with human resources staff, the facility failed to ensure	L 550		

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L 550	Continued From page 10 training and competency testing in Management of Disruptive Behaviors for 5/6 staff (Staff #1, 3, 4, 5 and 6). The findings include: 2/10/15 staff interview and review of training documentation for 6 sampled staff revealed no required training or competency testing in Management of Disruptive Behaviors for staff #1, 3, 4, 5 and 6.	L 550		
L 560	10.22.02.11.C2.e Staff Req-Dev-Train Indep Dut; Adm app;aging .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (2) All staff and care providers successfully complete the Administration's approved training to meet the specific needs of the individuals they serve and to carry out their assigned duties, such as training: (e) The aging process and the special needs of the elderly; and This Regulation is not met as evidenced by: Tag 560 [Site #|DL7418 Service|GH Individual #|8330, 8332. 8338, 8339, 8340]	L 560		

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L 560	Continued From page 11 Based on 10/30/14 review of 12 staff personnel files, 10/12 staff had not received current or updated training with verification of competencies as required. Based on 2/10/15 follow up review of 6 sampled direct care staff training records and interview with the Human Resources staff, the facility failed to ensure training and competency testing regarding the aging process for 1 staff (staff #1).	L 560		
L 565	10.22.02.11.C3 Staff Req-Dev-Train Indep Dut;All staff train .11 Staffing Requirements. C. The licensee shall develop and implement staff and care provider training and ensure through appropriate documentation that, before being assigned independent duties. (3) All staff and care providers receive training in blood-borne pathogens in accordance with OSHA guidelines found 29 CFR § 1910.1030, which is incorporated by reference. This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 12 staff personnel files, it was determined that 2/12 staff had not received current or updated training with verification of competencies as required. Based on 2/10/15 follow up review of 6 sampled direct care staff training records and interview with the Human Resources staff, the facility failed to ensure training and competency testing regarding blood-borne pathogens for 1 staff (staff #2).	L 565		

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L 570	10.22.02.11.D1 Staff Req-Rec Adm App Train 3; Com Integratio .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following: (1) Community integration and inclusion, This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 12 staff personnel files, it was determined that 1/12 staff had not received current or updated training with verification of competencies as required. Based on 2/10/15 follow up review of 6 sampled direct care staff training records and interview with the Human Resources staff, the facility failed to ensure training and competency testing in Community Integration & Inclusion for 1 staff.	L 570		
L 575	10.22.02.11.D2 Staff Req-Rec Adm App Train 3; Ind directed .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following: (2) Individual-directed, outcome-oriented planning for individuals, This Regulation is not met as evidenced by:	L 575		

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L 575	Continued From page 13 [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 2/10/15 review of 6 sampled direct care staff training records and interview with Human Resources staff, the facility failed to ensure training and competency testing in Individual Directed Outcome Oriented Planning for Individuals for 1/6 staff. The findings include: 2/10/15 staff interview and review of training documentation for 6 sampled staff revealed no required training or competency testing in Individual Directed Outcome Oriented Planning for Individuals for staff #1.	L 575		
L 580	10.22.02.11.D3 Staff Req-Rec Adm App Train 3;Gen Character .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training within 3 months of hire in the following: (3) General characteristics and needs of individuals served, This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 11 direct care staff training records and interview with Human Resources staff, it was determined that the licensee failed to verify the competency of 4/11 staff in required "General Characteristics and Needs of Individuals Served " training.	L 580		

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L 590	Continued From page 14	L 590		
L 590	10.22.02.11.D5 Staff Req-Rec Adm App Train 3;Fund rights .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following: (5) Fundamental rights of individuals with developmental disabilities, This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 12 direct care staff training records and interview with Human Resources staff, it was determined that the licensee failed to verify the competency of 1/12 staff in required "Fundamental Rights of Individuals with Developmental Disabilities" training.	L 590		
L 600	10.22.02.11.D6 Staff Req-Rec Adm App Train 3;Comm diseases .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following: (6) Communicable diseases, This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]	L 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	DD0239		C 02/10/2015

NAME OF PROVIDER OR SUPPLIER: SECOND FAMILY, INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 337 BRIGHTSEAT ROAD SUITE 111 LANDOVER, MD 20785

(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
L 600	Continued From page 15 Based on 10/30/14 review of 12 direct care staff training records and interview with Human Resources staff, it was determined that the licensee failed to verify the competency of 1/12 staff in required "Communicable Disease" training.	L 600		
L 605	10.22.02.11.D7 Staff Req-Rec Adm App Train 3;Make choices .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following: (7) Supporting individuals and families in making choices, and This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 12 direct care staff training records and interview with Human Resources staff, the licensee failed to verify the competency of 2/12 staff in required training "Supporting Individuals and Families in Making Choices".	L 605		
L 610	10.22.02.11.D8 Staff Req-Rec Adm App Train 3;Comm skills .11 Staffing Requirements. D. All staff and care providers shall receive Administration-approved training with 3 months of hire in the following:	L 610		

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L 610	Continued From page 16 (8) Communication skills. This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340] Based on 10/30/14 review of 12 direct care staff training records and interview with Human Resources staff, the Licensee failed to verify the competency of 1/12 staff in required training "Communication Skills".	L 610		
L 860	10.22.02.14.B6 QA-Dev a QA;Proactive strategies imp QA .14 Quality Assurance B. The licensee shall develop and implement a system of internal quality assurance which at a minimum: (6) Includes proactive strategies to improve the quality of services, including health and safety. This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|8330, 8332. 8338, 8339, 8340] Based on observation, record review, and interviews with staff, it was determined that the licensee failed to identify and address health and safety issues related to and following a self reported Incident (PCIS#28379). Findings include: 1. Failure for the licensee to report and document on the Agency's Incident Report (AIR) that staff on duty (September 30, 2014) providing care for Individual #8330 was Staff #18.	L 860		

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L 860	Continued From page 17 (See Deficiency Tag L515, Y2205, and Y2230 for details) 2. Failure for the licensee and licensee's delegating nurse/RN supervisor to retrain and provide in-service education to all staff regarding Nursing Care Plans and care of Individual #8330. (See Deficiency Tag L1105) 3. Failure for the licensee to remove Staff #18 from working in the licensee's program with children until MBON licensure was verified and Staff #18 received all required training and background checks. (See Deficiency Tag L515, Y2205, and Y2230 for details) 4. Failure for the licensee to address the lack of implementation of Individual #8330's Nursing Care Plan and physician's orders after the emergency room visit secondary to the development of). X-Ref Tag L900, L1105 and L1140	L 860		
L 900	10.22.02.14.E1.c QA-Standing Comm;Lic estab;Mon lic protocol .14 Quality Assurance E. Standing Committees. (1) The licensee shall establish a committee or committees to perform the following functions:	L 900		

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L 900	Continued From page 18	L 900		

(c) Monitor whether the licensee's protocol identified in §E(2) of this regulation is being properly implemented by reviewing all incidents in an effort to identify deficient practices and recommend necessary corrective action;

This Regulation is not met as evidenced by: Based on observation, staff interviews, review of medical record(s) and of the licensee's AIR for PCIS#28379, it was determined that the licensee's standing committee failed to conduct a thorough investigation to identify and address significant health and safety issues related to Individual #8330's ER visit when the licensee failed to: 1) accurately identify staff on duty at time of the incident; 2) implement an effective system to ensure completion of criminal background checks, licensure status, and certification(s) of staff; 3) implement an effective system to ensure staff reviewed and followed care plans; and 4) provide for training and retraining of staff as needed.

The findings include:

The Developmental Disabilities Administration's (DDA) Policy on Reportable Incidents and Investigations (PORII) indicates the following:

"Every agency shall develop an internal protocol to ensure compliance with this policy. The protocol shall establish operating procedures, to include the definition of responsibilities of the director or designee, employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigation, reviewing, addressing and monitoring the follow-up of incidents and identify trainings, other than the Policy on Reportable Incidents and

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L 900	Continued From page 19	L 900		
	Investigations (PORII), to be provided to assist in the completion of identified duties. The protocol shall also include provision for a standing committee and identify what trainings, in addition to the PORII, will be provided for standing committees. The agency ' s protocol shall also include the use of the Agency Investigation Report (AIR), formerly know as the Appendix 7 form, to investigate incidents that are reportable externally and internally, and the Standing Committee Review form, AIR Addendum, to document follow up and review of all incidents by the standing committee."			
	Section IXb of the Agency's Investigation Report states the following: "Explain any corrective, remedial, or disciplinary action that has occurred or will occur as a result of this incident for involved staff and/or systematically for this agency. Include a discussion of your agency's internal procedure for this type of incident, and whether staff followed the procedure." The licensee's response stated, "Staff counseled and in-serviced. Updated care plan. "			
	During the course of the investigation, interviews with the licensee's residential staff, RN supervisor, president, pediatric medical specialist, and administrative staff, and review of pertinent documentation, revealed that the agency could not provide any evidence of staff counseling or in-servicing as described in the above noted response (see also deficiency Tags L515, L1105, L1140, Y2205, and Y2230).			
	X-Ref Tag L860			
L1105	10.22.04.02.A1 Values-Values in IP;Wel Being;Health care ser	L1105		

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L1105	Continued From page 20	L1105		

.02 Values to be Considered in the Development of the IP.

A. Personal well-being, which includes:

(1) Receiving health care services that respond to the individual's needs and are consistent with those of the general population;

This Regulation is not met as evidenced by:
GLOBAL
Based on observation, record review and interview with staff, the licensee failed to ensure that all staff providing health care services for children were licensed, were trained, and were implementing the plan of care for all individuals in the home.

(See L515, L530, L545, L560, L565, L570, L575, L580, L590, L600, L605, L610, L1140, Y2205, Y2230 and Y5920 for details)

The following deficiencies are a result of the incident/complaint investigation (PCIS28379/MD00087192)

[Site #|DL7418 Service|GH Individual #|8330]

Based on record review and interview with licensee staff, it was determined that nursing staff 1) failed to ensure the implementation of foot care as indicated in the NCP, 2) failed to assess skin integrity for Individual #8330; and 3) failed to document evidence of turning and repositioning Individual #8330 every two hours as ordered by his physician and as indicated in the Nursing Care Plan (NCP).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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L1105	Continued From page 21 The findings include: 1. Failure to ensure implementation of foot care as indicated in the NCP. Pertinent documentation reviewed on 2/10/15, revealed that on 09/23/14, evening shift staff reported to night shift staff that Individual #8330 had bruises on and then the house RN was notified in the morning of 9/24/14. Review of the medical record revealed a nursing Care Plan was then initiated on 9/24/14 entitled, "Risk for Skin Breakdown Related to Pressure Point." The care plan specified that Individual #8330 would " However, staff did not follow this planned nursing intervention. One week later and before 7:30 am on the RN Supervisor received a call from the licensee's night shift LPN, concerning Individual #8330's . The clinical condition of the Individual's had deteriorated while staff had not followed the care plan and instead had the Individual . The assessment documentation indicated that the RN " and that Individual #8330's ! Individual #8330 was then transferred to a local emergency department for evaluation. 2. Failure to adequately assess Individual #8330's skin integrity Although the medical record revealed bruising on 9/23/14 that had worsened by 9/30/14, 19/19 nursing flow-sheets in the medical record revealed that staff inaccurately documented Individual #8330's skin was warm, dry and intact	L1105		

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L1105	Continued From page 22 with "no edema". 3. Failure to document turning and repositioning Individual #8330 every two hours as ordered by his/her physician and as indicated in Individual #8330's Nursing Care Plan (NCP). The licensee's "Nursing Flow Sheet" from 9/23/14 through 9/30/14 revealed only 4 out of 19 LPN staff wrote notes documenting repositioning Individual #8330. The Medication Administration Record (MAR) provided a space for documenting turning and repositioning every two hours but the September documentation was blank. Interview with the house manager revealed that staff also kept no documentation of a turning log. During an interview with the licensee's delegating RN on November 12, 2014, the surveyor indicated that no documentation was found to show that Individual #8330 was being turned every two hours as ordered by the physician and as directed in the nursing care plan. Nonetheless, the licensee's DN/RN supervisor stated that staff did not need to turn Individual #8330 because Individual #8330 favored one position and could turn back to that position. This also applies to Deficiency Tag L515, L530, L1140	L1105		
L1140	10.22.04.02.B3 Values-Values in IP;Ind rights;free of neglic .02 Values to be Considered in the Development of the IP. B. Individual rights, which include:	L1140		

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L1140	Continued From page 23	L1140		

(3) Being free from abuse, neglect, and mistreatment;

This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]

Based on observation, record review and interviews, it was determined that the licensee failed to ensure that individuals received adequate and sufficient care services to meet their health care and safety needs. Incident specific findings of neglect affected 1 out of 5 Individuals in the home.

The findings include:

According to the Developmental Disabilities Administration's (DDA's) Policy on Reportable Incidents and Investigations (PORII), neglect is defined as "the failure to provide proper care and attention to an individual that results in significant harm or jeopardy of harm to the individual's health, safety, or well-being; failure to provide necessities such as food, clothing, essential medical treatment, adequate supervision, shelter or a safe environment."

The following deficiencies are a result of the Incident/Complaint investigation (see PCIS28379/MD00087192)

[Site #|DL7418 Service|GH Individual #|8330]

Findings Include:

1. Failure to properly assess and document skin integrity (see Deficiency Tag L1105 for details).
2. Failure to properly document turning Individual

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L1140	Continued From page 24	L1140		
	every two hours as ordered and planned (see Deficiency Tag L1105 for details). 3. Failure to properly implement NCP related to foot care (see Deficiency Tag L1105 for details). 4. Failure to provide adequate documentation of staff training on the NCP at the time of incident (see Deficiency Tag L530 and L1105 for details). 5. Failure to ensure that staff working on the day of the incident (PCIS28379) had received a criminal background check prior working with Individual #8330. (see Deficiency Tag L515, Y2230) 6. Failure to verify MBON licensure prior to being assigned independent duties as an LPN, including the administration of medications. (See Deficiency Tag L515, Y2205) 7. Failure to provide sufficient evidence of staff being trained and in-serviced on Individual #8330's NCP as indicated in the licensee's Agency Investigation Report (AIR) GLOBAL Findings include: 1. Failure to ensure that all staff received required training; 2. Failure to develop behavior plans for Individual #8330 and Individual #8332; 3. Failure to ensure that staff working in the licensee's program received a criminal background check prior to working with the children 4. Failure to verify current nursing licensure prior to assignment of independent duties as an LPN X-Ref Tags L412, L430, L515, L530, L545, L560,			

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L1140	Continued From page 25 L565, L570, L575, L580, L590, L600, L605, L610, L1105, Y2205, Y2230	L1140		
L9999	Final Comments and Rating Individual #1 was year-old whose diagnoses included Individual #2 was a year-old whose diagnoses included Individual #8330 was a year-old whose diagnoses included Individual #8332 was year-old whose diagnoses included Individual #8338 was a year-old whose diagnoses included	L9999		

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L9999	Continued From page 26 Individual #8339 was a year-old whose diagnoses include Individual #8340 was year-old whose diagnoses included	L9999		
Y2205	14.31.06.05D2 Personnel Admin: Doc Emp Mt/Exc Job Qual .05 Personnel Administration. D. The licensee shall: (2) Document that all employees meet or exceed the minimum qualifications for their positions; This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|8330, 8332. 8338, 8339, 8340] Based on staff interview and personnel records, it was determined that the licensee failed to verify that Staff #18 was a Licensed Practical Nurse authorized to practice in the State of Maryland. The findings include: According to the Maryland Board of Nursing	Y2205		

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Y2205	Continued From page 27 (MBON), all persons who hold a license must practice under the name in which their license has been issued and appears on the MBON web site. Review of personnel files and interview with the licensee's Human Resources staff revealed that the licensee had not verified licensure of staff #18. Staff #18's personnel file reflected a maiden name, which had changed. No nurse with the name that the licensee had for staff #18 was authorized to practice by the Board. Lacking an effective process for verification, staff #18 was practicing under a name that could not be verified. On December 2, 2014 the OHCQ issued an Immediate Notification of noncompliance with regulatory standards. During the February 10, 2014 onsite follow up, 3/19 additional personnel records (Staff #7 CNA, #18 LPN, and #20 LPN) revealed expired license or certification status in the active personnel files. All three held current status with the MBON, but an effective process for verification by the licensee was still not in place, as evidenced by the three inaccurate personnel files.	Y2205		
Y2230	14.31.06.05D7 Personnel Admin: CBC, CPS Request B4 Work .05 Personnel Administration. D. The licensee shall: (7) Ensure that requests for a criminal background check in accordance with COMAR 12.15.02 and Child Protective Services	Y2230		

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Y2230	Continued From page 28 clearances have been submitted for each prospective employee before the employee begins work at the program. This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|8330, 8332. 8338, 8339, 8340] Based on 10/30/14 record review and interview with staff, it was determined that the licensee failed to ensure that Staff #18 had a criminal background check prior to starting to practice as a Licensed Practical Nurse at the agency. Findings Include: Interview with the licensee's president and human resource director and review of employee personnel records revealed Staff #18 was currently working at site DL7418 without completion of a criminal background check. On December 1, 2014 at 12:20 PM issued a verbal Immediate Notification of noncompliance with regulatory standards followed up in writing.	Y2230		
Y2460	14.31.06.05H2a Personnel Admin: Stfg Plan: Hlth/Sfty Needs .05 Personnel Administration. H. Staffing Plan. The licensee shall: (2) Develop and implement a staffing plan that: (a) Addresses the health and safety needs of	Y2460		

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Y2460	Continued From page 29 each child; This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|8330, 8332. 8338, 8339, 8340] Based on observations, record review and interview with licensee's staff, it was determined that the licensee failed to implement a staffing plan that addressed the health and safety needs of 7 out of 7 Individuals reviewed. Findings Include: See Tag L515, L530, L1105, L1140 for details.	Y2460		
Y2495	14.31.06.06A1b Emp Duties: Prog Admin: Policy Implem .06 Employee Duties and Qualifications. A. Program Administrator. (1) The licensee's board of directors shall employ a program administrator who is responsible for: (b) Implementation of all policies; This Regulation is not met as evidenced by: GLOBAL [Site #|DL7418 Service|AL Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]	Y2495		

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	DD0239		C 02/10/2015

NAME OF PROVIDER OR SUPPLIER: SECOND FAMILY, INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 337 BRIGHTSEAT ROAD SUITE 111 LANDOVER, MD 20785

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Y2495	Continued From page 30	Y2495		
	Based upon a review of records, observations and interview, the licensee's program administrator failed to ensure implementation of policies and procedures related to compliance with the DDA's training requirements and Policy on Reportable Incidents and Investigations, and the licensee's employment policies and procedures. This applies to all deficiencies cited.			
Y4715	14.31.06.17C2b Adm/ISP/BP/Dc: ISP: 30 Days-BP, If Necc	Y4715		
	.17 Admission, Individual Service Plan, Behavior Plan, and Discharge.			
	C. Individual Service Plan. The licensee shall:			
	(2) Within 30 days after admission, develop for each child an individual service plan that identifies:			
	(b) A behavior plan, if appropriate;			
	This Regulation is not met as evidenced by: Site #|DL7418 Service|GH Individual #|1, 2, 8330, 8332. 8338, 8339, 8340]			
	Based on record review and interview with staff, it was determined that the licensee failed to develop an updated Behavior Plan in accordance with 10.22.02.10 for 4 out of 7 Individuals reviewed. This has the potential to affect the health and safety of all Individuals in the home.			
	The findings include:			

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Y4715	Continued From page 31	Y4715		

1. Individual #1 was admitted more than 30 days prior to a 2/10/15 review. Review of the medical record on 2/10/15 revealed diagnoses including ", ". However, no behavioral care plan was found documented in the medical record for Individual #1.
2. Individual #2 was admitted more than 30 days prior to a 2/10/15 review. Review of the medical record revealed a behavioral diagnoses that would reflect concerns with The initial nursing assessment completed on did not include a behavioral assessment but included a note stating that the "Individual is new to us and will be scheduled for <his/her> first psych visit.". However, more than two months later, during medical record review on 2/9/15, no behavioral care plan was found in the medical record for Individual #2.
On 2/10/15, the house manager provided a copy of a new behavioral care plan that social work staff had developed for Individual #2 and that was received at the home in the late afternoon on 2/9/15. In interview with the house manager, she reported that although the behavioral care plan was by then in the home, it could still not be placed into the record for staff review, because the plan was not yet approved by the Standing Committee. When asked why the behavioral care plan was not completed sooner, the house manager indicated that the social work staff is contracted and can't always come right away.
2/10/15 review of the medical record revealed that Individual #2 also had diagnosis of

but no care plan related to was found in the medical record.
3. 2/10/15 review of the medical record revealed

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Y4715	Continued From page 32 that Individual 8332 had diagnoses including but no care plan related to was found in the medical record. 10/30/14 review of the medical record revealed that Individual #8332 most recent behavior plan was dated March 10-13, 2013. There was no documentation of an updated behavior plan. Licensee staff was made aware of this finding. Further review revealed that page 6 of the behavior plan developed and implemented by the licensee did not implement protocols that adequately protect the other individuals from harm if Individual #8332 displays Last, in follow up review on 2/10/15, an updated plan dated 12/18/14 was noted in the medical record. However, the signature sheet showing staff reviewed and were familiar with the behavioral care plan after more than 2 months, 11/20 staff still had not signed off that they reviewed the behavior plan. 4. 2/10/15 review of the medical record for individual #8339 revealed many notes regarding behavioral concerns including . A note entered on 1/8/15 stated that individual #8339 " " On 2/2/15, another note reflected that the individual at staff. However, during medical record review on 2/9/15, no behavioral care plan was found in the medical record.	Y4715		
Y5800	14.31.07.08B Spec Lic Std: DD: QA: Mt 10.22.02.14 .08 Programs for Children With Developmental Disabilities.	Y5800		

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Y5800	Continued From page 33 B. Quality Assurance. The licensee shall conform to the quality assurance standards established in COMAR 10.22.02.14. This Regulation is not met as evidenced by: [Site #|DL7418 Service|GH Individual #|8330, 8332. 8338, 8339, 8340] Based on observation, record review and staff interviews, the licensee failed to: 1. Develop and implement a system of internal quality assurance which included proactive strategies to improve the quality of services, including health and safety in accordance with COMAR 10.22.02.14B6. (See Deficiency Tags L515, L0860. Y2205, and Y2230) 2. Establish a Standing Committee or committees that monitored whether the licensee's protocol was being properly implemented by reviewing all incidents in an effort to identify deficient practices and recommend necessary corrective action in accordance with COMAR 10.22.02.14E1c. (See Deficiency Tag L0900)	Y5800		
Y5910	14.31.07.08K4 Spec Lic Std: DD: Policy: Incident Rptg .08 Programs for Children With Developmental Disabilities. K. Policies and Procedures. A licensee shall develop and adopt written policies and procedures in addition to those policies and procedures required in COMAR 14.31.06 to ensure:	Y5910		

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Y5910	Continued From page 34	Y5910		
	(4) The reporting and investigation of all incidents, including those involving life-threatening conditions, in accordance with the Developmental Disabilities Administration's procedures on reportable incidents;			
	This Regulation is not met as evidenced by: This is a GLOBAL deficiency			
	[Site #|DL7418 Service|GH Individual #|8330, 8332. 8338, 8339, 8340]			
	Based on December 2014 observations, record review, interview with staff, Agency policies and procedures on incidents and investigations and review of a self reported incident, it was determined that the Licensee failed to ensure that it's policies and procedures were updated to reflect compliance with the Developmental Disabilities Administrations (DDA) Policy on Reportable Incidents and Investigations (PORII).			
	Findings include:			
	Review of the agency's policy's and procedures reveal that the policy is from 2008 and does not include the current standards of reporting via PCIS or in accordance with the DDA's PORII as listed in background and intent. (see also Deficiency Tag L900).			
Y5920	14.31.07.08K6 Spec Lic Std: DD: Policy: Comply 10.27.11	Y5920		
	.08 Programs for Children With Developmental			

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Y5920	Continued From page 35 Disabilities. K. Policies and Procedures. A licensee shall develop and adopt written policies and procedures in addition to those policies and procedures required in COMAR 14.31.06 to ensure: (6) Compliance with COMAR 10.27.11; This Regulation is not met as evidenced by: [Site #|DL7418 Service|AL Individual #|8330, 8332. 8338, 8339, 8340] Based upon a review of records it was determined that the Agency failed to ensure compliance with the following COMAR 10.27.11 regulatory standards: 1. Failure to ensure compliance with COMAR 10.27.11.02.B21: "Supervision means the process of critical watching, directing, and evaluating another's performance" and 2. failure to ensure compliance with COMAR 10.27.11.04.C2 04 Supervision: " For the client whose health status meets the criteria as stated in Regulation .03F of this chapter the registered nurse managing the case shall make a supervisory visit to the client's residence at a minimum of every 45 days to: Evaluate the nursing acts to be delegated" Based on observation, record review and interview with staff, it was noted that the Delegating RN/RN Supervisor failed to adequately assess and ensure through	Y5920		

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Y5920	Continued From page 36	Y5920		

documentation that all staff providing care for Individuals #8330, #8332, #8338, #8339, and #8340 had been adequately trained in Individual #2519's Nursing Care Plan. While there was documentation of sign in sheet that for staff to read the nursing care plan and sign, there was no documentation of any Individual Specific staff trainings or in-service education in the staff employee records in the Agency's administrative office, at the residential site, or produced by the Agency's Delegating Nurse that verifies the Agency's Delegating Nurse had reviewed the contents of the Nursing Care Plan with all the staff for which the tasks had been delegated.

Further record review and interview with staff revealed that the House Manager had not been provide in-service education and did not know of any in-service by the Licensee's Nurse Supervisor concerning implementation of Individual #8330's NCP following his ER (Emergency Room) visit on 9/30/14.

X-Ref Tag L0530, L1105 and L1140

3. Failure to ensure compliance with COMAR 10.27.11.04.C1, Supervision:
"For the client whose health status meets the criteria as stated in Regulation .03F of this chapter the registered nurse managing the case shall make a supervisory visit to the client ' s residence at a minimum of every 45 days to evaluate the client ' s health status."

Based on observation and record review it was determined that the Licensee's Initial and 45-Day Assessments were incomplete.

The findings include:

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Y5920	Continued From page 37	Y5920		

The December 2014 45-day assessment form which includes review of diagnoses, medications and physician appointments, did not document any review of the Individual ' s physical systems (head to toe assessment) completed by the RN; and both the initial and 45-day reviews failed to sufficiently document review of medications and diagnoses. This concern was evident for 3 of 7 Individuals reviewed.

The findings include:
Review of the initial nursing assessment for Individual #2 revealed a list of three medications. These three listed medications did not include any doses, frequencies, routes, or indication for use, and no indication was found demonstrating any assessment regarding the medications was documented.
Review of the medical record on 2/10/15 revealed that the initial nursing assessment for Individual #8332 did not reflect two of the Individual ' s diagnoses. The initial nursing assessment for Individual #8332 also revealed an incomplete list of medications. The listed medications did not include frequency, route, or indication for use, and no indication was found demonstrating any assessment regarding the medications listed. Also, an incomplete list of diagnoses and no medication review was evident in the 45-day nursing assessment completed during November 2014.
Review of the initial nursing assessment for Individual #8339 revealed that no medications were listed, reviewed or assessed. The portion of the assessment documentation was left entirely blank.