

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

PRINTED: 05/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 121 TUCKERMAN ST, NE WASHINGTON, DC 20011
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(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
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W 000 INITIAL COMMENTS

A re-certification survey was conducted from 5/10/2011 through 5/12/2011. A random sampling of two clients was selected from a population of four individuals with varying degrees of disabilities.

This re-certification was completed utilizing the fundamental survey process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.

W 000

Received 6/3/11

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 140 483.420(b)(1)(i) CLIENT FINANCES

The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure an accurate accounting of all clients' funds for one of two sampled clients. [Client #2]

The finding includes:

Record review on 5/12/2011 at 3:38 p.m. revealed \$200.00 was withdrawn from Client #2's account on 6/10/2010. Further review revealed there were no receipts on file to substantiate what this money was spent on.

Interview with qualified intellectual disability professional (QIDP) on 5/12/2011 at 3:39 p.m.

W 140

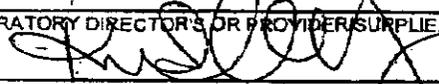
W140

Client #2 \$200.00 withdrawal was for spending money for his vacation to Ocean City, MD from 6/19/10 - 6/26/10. Client #2 receipts for purchases were given to the Director of Programs at an off-site training by the staff assigned to Client #2. Director of Programs verified the purchase receipts and later misplaced the receipts.

A statement attesting to the misplacement of the receipts and verification of the items purchased was written by the Director of Programs and placed in Client #2's finance book.

Program Manager and QDDP, in conjunction with My Own Place, Inc.'s accounting department will continue to adhere to the current policy of submitting receipts within 7 days after a vacation and to balance accounts each month for each individual to ensure accurate and timely accounting of all clients' financial records and to prevent loss of purchase receipts.

6/1/11 - Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 6/2/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 140 Continued From page 1
confirmed the facility did not have any receipts on hand for the 6/10/2010 withdrawal. The QIDP indicated the receipts were misplaced by staff and were unavailable at the time of survey.

W 140

As of the date of survey, there was no evidence presented or on file to substantiate the facility maintained a full and accurate accounting of Client #2 's finances as required by this section.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

W159
Client #1 had a custom molded wheelchair to use for distance in the community on order prior to his move to our facility on 4/5/11. QDDP and Director of Nursing have been working diligently to clarify specifications and funding since his arrival. We anticipate that all issues should be clarified by the end of June 2011. In the meantime, Client #1 has access to another wheelchair for community use. The Director of Health Services will continue to oversee the procurement of adaptive equipment and identify alternate sources if delivery is delayed.

6/30/11
Ongoing

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three clients in the sample. (Clients #1 and #2)

The finding includes:
The facility's QIDP failed to ensure all clients were provided their prescribed adaptive equipment for one of two sampled clients. [See W436]

W 368 483.460(k)(1) DRUG ADMINISTRATION

W 368

W368
See response on page 3 of 6

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

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W 368 Continued From page 2
This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure all medications were administered as prescribed for one of two sampled clients. [Client #3]

The finding includes:

[Reference W369]

On 5/10/2011 at 5:40 p.m., Client #3 received 20mg of Citalopram (Celexa) for depression. Record review and interview on 5/11/2011 revealed the medical staff failed to ensure this medication was administered in compliance with the 5/2011 physician's orders.

W 368

W368
To ensure accurate administration of medication to all clients, effective immediately, the facility RN has informed all staff that bedtime medication should be given no earlier than 8pm. The Agency nurse will also re-train staff including medication nurse on medication administration by 06/15/11 and conduct periodic spot checks during medication pass to ensure compliance.

6/15/11
Ongoing

W 369 483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure accurate medication administrations for one of two sampled clients. [Client #3]

The findings include:

Observation on 5/10/2011 at 5:40 p.m. revealed Client #3 received 20mg of Citalopram (Celexa) for depression. Interview with the attending nurse on the same day at approximately 6:01 p.m. revealed all "bed time" medications should be administered just before the client goes to sleep at around 8:00 p.m.

W 369

W369
See Response to W368

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W 369 Continued From page 3

Review of Client #1 's 5/2011 physician 's orders on 5/11/2011 at 10:02 a.m. revealed his prescribed dosage of " Citalopram HBR 20mg Tablet (Celexa) " was written to be administered " at bedtime. " Further interview with the supervisory registered nurse (SRN) on 5/11/2011 at 10:20 a.m. confirmed the physician 's order prescribing the Citalopram to be administered at bedtime and that it should have been administered at that time.

W 369

At the time of the survey, there was no evidence presented or on file to substantiate that the facility ensured all medications were administered without error.

W 436 483.470(g)(2) SPACE AND EQUIPMENT

W 436

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.

W436

See response on page 5 of 6

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure all clients were provided their prescribed adaptive equipment for one of two sampled clients. (Client #1)

The findings include:

1. Observation on 5/10/2011 beginning at 9:00 a.m. revealed Client #1 walked with an unsteady gait and required the use of a walker and staff

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W 436 Continued From page 4 assistance to get around the facility.

Review of Client #1's physician's orders on 5/11/2011 at 10:04 a.m. revealed he was prescribed to receive a " wheelchair for community outings " on 4/5/2011.

Interview with the facility ' s qualified intellectual disability professional (QIDP) on 5/11/2011 at 10:37a.m., revealed the facility has not taken any measures to secure him his own wheelchair. According to the QIDP, they also have not been utilizing a wheelchair on all community outings as prescribed. The QIDP further revealed they only use the wheelchair if he is expected to walk for long distances. Which at that point, they would borrow a wheelchair from another facility to accommodate the outing.

The facility failed to ensure client #1 be provided a wheelchair as prescribed to ensure his health and safety on all community outings.

2. Observation on 5/10/2011 beginning at 9:00 a.m. revealed Client #1 walked with an unsteady gait and required the use of a walker and staff assistance to get around the facility.

Record review on 5/11/2011 at 10:04 a.m. revealed Client #1 ' s 4/10/2011 Physical Therapy assessment recommended that " he may also need either bed railings (e.g. Hospital bed) or perhaps a mattress with an alarm to alert staff when he is getting out of bed. "

Interview with the supervisory registered nurse (SRN) and QIDP on 5/12/2011 at 2:55 p.m. confirmed no actions to secure a hospital bed or

W 436

W436

1. See Response to W159
2. A mattress alarm system was ordered for Client #1 on 5/12/11 and installed on 5/23/11 and staff trained were trained on it's use on 5/23/11
3. Client #1 has an orthopedic appointment on 06/08/11 for evaluation and to obtain prescription for shoes recommended by the podiatrist.

The QDDP and RN will review all medical/clinical consults monthly to ensure prescribed adaptive equipment is available in good repair and properly utilized. Further the Director of Health Services will be notified by the RN when issues arise to elevate need. All efforts will be documented.

6/30/11

5/23/11

6/20/11

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W 436 Continued From page 5
mattress with an alarm has taken place to date. In addition, the QIDP confirmed she was not aware of the recommendation prior to the survey.

There was no evidence presented or on file at the time of survey to substantiate that any action had been undertaken to secure either the alarmed mattress or the bedrails for this client.

3. Observation on 5/10/2011 beginning at 9:00 a.m., revealed Client #1 walked with an unsteady gait and required the use of a walker and staff assistance to get around the facility. He was also observed wearing a pair of traditional sneakers on both days of survey.

Record review on 5/11/2011 at 1:48 p.m., revealed Client #1's 3/28/2011 Podiatry assessment prescribed that he be provided "Extra depth shoes with laminated insoles."

Interview with the supervisory registered nurse (SRN) and QIDP on 5/12/2011 at 2:57 p.m., revealed no actions have been taken to secure the shoes prescribed by the Podiatrist for Client #1 to use. In addition, the QIDP confirmed she was not aware of the recommendation prior to the survey.

There was also no evidence presented or on file at the time of survey to substantiate that any action had been undertaken to secure this adaptive equipment.

W 436

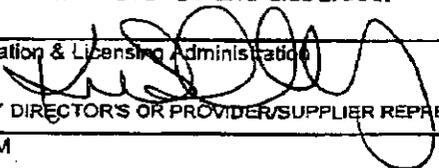
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I 000	<p>INITIAL COMMENTS</p> <p>A re-certification survey was conducted from 5/10/2011 through 5/12/2011. A random sampling of two residents was selected from a population of four individuals with varying degrees of disabilities.</p> <p>The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.</p>	I 000		
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three residents in the sample. (Residents #1 and #2)</p> <p>The finding includes: [Reference Federal Deficiency Citation W159] The facility's QIDP failed to ensure all residents were provided their prescribed adaptive equipment for one of two sampled residents.</p>	I 180	<p>I180 Client #1 had a custom molded wheelchair to use for distance in the community on order prior to his move to our facility on 4/5/11. QDDP and Director of Nursing have been working diligently to clarify specifications and funding since his arrival. We anticipate that all issues should be clarified by the end of June 2011. In the meantime, Client #2 has access to another wheelchair for community use. The Director of Health Services will oversee the procurement of adaptive equipment and identify alternate sources if delivery is delayed</p>	6/30/11 Ongoing
I 189	<p>3508.7 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall maintain records of residents funds received and disbursed.</p>	I 189	<p>I189 See response page 2 of 5</p>	

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CSO (X6) DATE 6/3/11
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I 189	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure an accurate accounting of all residents funds for one of two sampled residents. [Resident #2]</p> <p>The finding includes:</p> <p>Record review on 5/12/2011 at 3:38 p.m. revealed \$200.00 was withdrawn from Resident #2 ' s account on 6/10/2010. Further review revealed there were no receipts on file to substantiate what this money was spent on.</p> <p>Interview with qualified intellectual disability professional (QIDP) on 5/12/2011 at 3:39 p.m. confirmed the facility did not have any receipts on hand for the 6/10/2010 withdrawal. The QIDP indicated the receipts were misplaced by staff and were unavailable at the time of survey.</p> <p>As of the date of survey, there was no evidence presented or on file to substantiate the facility maintained a full and accurate accounting of Resident #2 ' s finances as required by this section.</p>	I 189	<p>I189</p> <p>Client #2 \$200.00 withdrawal was for spending money for his vacation to Ocean City, MD from 6/19/10 – 6/26/10. Client #2 receipts for purchases were given to the Director of Programs at an off-site training by the staff assigned to Client #2. Director of Programs verified the purchase receipts and later misplaced the receipts.</p> <p>A statement attesting to the misplacement of the receipts and verification of the items purchased was written by the Director of Programs and placed in Client #2's finance book.</p> <p>Program Manager and QDDP, in conjunction with My Own Place, Inc.'s accounting department will continue to adhere to the current policy of submitting receipts within 7 days after a vacation and to balance accounts each month for each individual to ensure accurate and timely accounting of all clients' financial records and to prevent loss of purchase receipts</p>	06/01/11
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the GHDP failed to ensure all staff was afforded the opportunity to review their job descriptions on an annual basis as required by this section.</p> <p>The finding includes:</p>	I 203	<p>I203</p> <p>See response on page 3 of 5</p>	

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I 203	<p>Continued From page 2</p> <p>Record review on 5/12/2011 at approximately 4:30 p.m. revealed there was no valid (signed/dated) Job Description review form on file for Staff #4, Staff #6 and Staff #8. Interview with the facility's qualified intellectual disability professional (QIDP) on 5/12/2011 at approximately 4:35 p.m. confirmed that none of these staff had a valid Job Description review form on file. The QIDP indicated she would contact the main office to see if she could secure a copy of the documents.</p> <p>The GHIDP failed to ensure all staff had the opportunity to review their job descriptions over the past licensure year. There was no evidence on record at the time of survey to substantiate that all staff were afforded an opportunity to review their job descriptions as required by this section.</p>	I 203	<p>I203</p> <p>All outstanding staff job descriptions will be signed and placed in their personnel file by 6/15/11</p> <p>QDDP and Program Manager will ensure that all staff review and sign their job descriptions on an annual basis. A system has been put in place to have staff review and sign their job descriptions annually as part of their performance evaluation. Additionally, quality assurance monitoring will review a random sample of personnel files quarterly to ensure compliance.</p>	6/15/11
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I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all staff secured an annual health screening to ensure the health and safety of its residents for two of ten staff and for two of eight contracted</p>	I 206	<p>I206</p> <p>See response on page 4 of 5</p>	
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I 206	<p>Continued From page 3</p> <p>professionals. [Staff #4 and #7][Contractors #4 and #6]</p> <p>The finding includes:</p> <p>Record review on 5/12/2011 at approximately 4:40 p.m. revealed there was no current health certificate on file for Staff #4, #7 and Contractor #4 and #6. Interview with the facility's qualified intellectual disability professional (QIDP) on 5/12/2011 at approximately 4:45 p.m. confirmed that none of these staff had a valid health certificate on file. The QIDP indicated she would contact the main office to see if she could secure a copy of the documents.</p> <p>There was no evidence on record at the time of survey to substantiate that all staff had secured a current health screening as required by this section.</p>	I 206	<p>I206</p> <p>Health Certificate for staff #4 was secured on 5/13/11 and placed in the file. All other staff with outstanding health certifications will be secured and placed in files by 6/15/11</p> <p>M.O.P. Human Resource Department will ensure that all staff secure an annual health screening (physician's certificate) to ensure the health and safety of its individuals. These certificates will be maintained in the staff personnel files for review. When staff that are not in compliance, they will be placed on administrative leave without pay. Additionally, quality assurance monitoring will review a random sample of personnel files quarterly to ensure compliance.</p>	6/15/11 Ongoing
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHIDP) failed to ensure all staff maintained current CPR and First Aid certifications for six out of ten staff as required by this section. [Staff #4, #5, #6, #7, #8 and #10]</p>	I 227	<p>I227</p> <p>All staff except two had current CPR and First Aid cards. However, cards were not copied and filed in staff records. Those cards have all been copied and placed in the staff records. All staff with outstanding CPR and First Aid certificates will have them secured and placed in files by 6/15/11</p> <p>M.O.P. Training Department, QDDP and Program Manager will ensure that all staff are notified monthly of trainings and the importance of attending. In cases when staff are not in compliance, they will be placed on administrative leave. Additionally, quality assurance monitoring will review a random sample of personnel files quarterly to ensure compliance and copies of completed cards are in files.</p>	6/15/11 Ongoing

PRINTED: 05/25/2011
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0231	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 121 TUCKERMAN ST, NE 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) COMPLETE DATE
I 227	<p>Continued From page 4</p> <p>The findings include:</p> <ol style="list-style-type: none"> Record review on 5/12/2011 at approximately 4:50 p.m. revealed there was no cardiopulmonary resuscitation (CPR) certificates on file for Staff #4, #5, #6, #7, #8 and #10. Record review on 5/12/2011 at approximately 5:25 p.m. revealed there was no first aid certificate on file for Staff #6, #7 and #8. <p>Interview with the facility's qualified intellectual disability professional (QIDP) on 5/12/2011 at approximately 5:30 p.m. confirmed that none of these staff had either a valid CPR or First Aid certificate on file. The QIDP indicated she would contact the main office to see if she could secure a copy of these documents.</p>	I 227		