

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2011
NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA		STREET ADDRESS, CITY, STATE, ZIP CODE 1785 VERBENA ST NW WASHINGTON, DC 20012	
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R 000	INITIAL COMMENTS An annual licensure survey was conducted on June 23, 2011. A random sampling of three residents was selected from a population of five females with various levels of intellectual disabilities. The findings of the survey were based on observations at the group home, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	R 000	<p style="text-align: right;"><i>Received 7/20/11</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 800 North Capitol St., N.E. Washington, D.C. 20002</p>
R 124	4701.4 BACKGROUND CHECK REQUIREMENT The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. This Statute is not met as evidenced by: Based on interview and review of the records the Group Home for Person's with Intellectual Disabilities (GHPID) failed to ensure all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. The finding includes: Review of personnel records on June 23, 2011, beginning at approximately 4:30 p.m., revealed that Staff #4 began employment on November 15, 2010. At the time of the survey, there was no documented evidence that a background check had been obtained for Staff #4.	R 124	<p>R 124 Volunteers of America Chesapeake, Inc/DC Community Living Centers completes background check (EBI) before hiring every employee. The original is maintained in the main office. A review was conducted following the survey and the background check for M. H. has been placed in the personnel file at the program office. CORRECTION-7/20/11</p> <p style="text-align: right;">7/1/11</p>

Health Regulation & Licensing Administration

Kevin S. Loper - Clark
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

TITLE
Program Director
(X6) DATE
7-17-11

6899

A1M011

If continuation sheet 1 of 1

Correction Submitted 7/20/11

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I 165	<p>Continued From page 1</p> <p>records at approximately 11:00 a.m. revealed a policy entitled "Medication Administration" which stated "Medication passes are to be completed within one hour (30 minutes prior to prescribed time up to 30 minutes after).</p> <p>During a face to face with the LPN on June 22, 2011 at approximately 11:30 a.m., she stated "I don't have a reason for why I passed her medicines late."</p> <p>2. On June 22, 2011 at approximately 9:00 a.m., the LPN was observed administering medication to Resident #4. The observation revealed the LPN offered Resident #4 medications more than three times.</p> <p>Further record review of the administrative records at approximately 11:00 a.m. revealed a policy entitled "Medication Refusal" which stated "The non-licensed staff and/or nurse who encounters a medication refusal, shall not attempt to force the person to take the medication. Medications will be offered a minimum of three times within the allotted period for the medication passes.</p> <p>During a face to face interview with the LPN on June 22, 2011 at approximately 9:15 a.m., she stated " I would keep offering her the medications until she takes it. "</p>	I 165	<p>2. Volunteers of America Chesapeake, Inc/DC Community Living Centers will ensure all nurses are properly trained on Medication Refusal Policy. The RN will implement a system to randomly monitor medication pass of LPN's at least quarterly via documented observation of the LPN. Training will be completed at least annually and as revisions to the medication refusal policy occur.</p> <p>7/22/11</p>
I 378	3519.10 EMERGENCIES	I 378	<p>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</p>

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I 379	Continued From page 2 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 Group Home for Persons with Individual Disabilities (GHPID) failed to ensure unusual incidents that interfered substantially with the resident's health was reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3510.10), for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: 1. Review of the facility's incident reports on June 23, 2011 at approximately 10:52 a.m. revealed an incident report dated November 25, 2010 involving Resident #4. According to the report, an individual from the community reported he had observed Resident #4 being verbally abused and pushed out of a local grocery store. Interview with the Residential Coordinator/Incident Management Coordinator (RC/IMC) on June 23, 2011, at approximately 11:16 a.m. revealed when the staff was contacted to be placed on administrative leave she decided to resign from the position. At the time of the survey, the GHPID failed to ensure the Department of Health, Health Regulations and Licensing Administration Division (DOH/HRLA) was notified of the	I 379	1379 I-5. Volunteers of America Chesapeake, Inc/DC Community Living Centers Incident Management Coordinator has revised the current system by ensuring phone notifications are made immediately to the IMC who will then make the proper notifications to outside agencies within 24hrs (i.e. Department of Health, Health Regulations Licensing Administration, DDS, etc.). The incident Management Coordinator has received training requiring the reporting of incidents in a timely manner to DOH/HRLA, DDS, and Program Director & Director of Operations.	7/22/11

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I 379	Continued From page 3 aforementioned incidents within twenty-four hours. It should be noted the incident was reported on November 30, 2010. 2. Review of the facility's incident reports on June 23, 2011 at approximately 9:45 a.m. revealed an incident report dated January 28, 2011 involving Resident's #1, #2, #3, #4 and #5. According to the report, all the client's were taken to the Comfort Inn on January 28, 2011 and returned to the facility on January 30, 2011 due to a power outage. Further review of the incident report revealed the facility notified DOH/HRLA on June 23, 2011 at 5:00 p.m. via fax. During a face to face interview with the RC/IMC on June 23, 2011 at approximately 1:00 p.m., she stated " I faxed the report late." There was no documented evidence the DOH/HRLA was notified within 24 hours. 3. Review of the facility's incident reports on June 23, 2011 at approximately 9:45 a.m. revealed an incident report dated January 31, 2011 involving Resident #1. According to the report, the residents hands were swollen upon returning from the day program. Further review of the incident report revealed the facility notified the DOH/HRLA on June 14, 2011 at 11:00 a.m. via fax. During a face to face interview with the RC/IMC on June 23, 2011 at approximately 1:00 p.m., she stated " I faxed the report late." There was no documented evidence the DOH/HRLA was notified within 24 hours.	I 379			

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I 379	<p>Continued From page 4</p> <p>4. Review of the facility's incident reports on June 23, 2011 at approximately 9:45 a.m. revealed an incident report dated April 4, 2011 involving Resident #1. According to the report, the resident had a bruise on the left side. DOH/HRLA was notified on June 14, 2011 at 10:10 a.m. via fax.</p> <p>During a face to face interview with the RC/IMC on June 23, 2011 at approximately 1:00 p.m., she stated " I faxed the report late."</p> <p>There was no documented evidence the DOH/HRLA was notified within 24 hours.</p> <p>5. Review of the facility's incident reports on June 23, 2011 at approximately 9:45 a.m. revealed an incident report dated June 4, 2011 involving Resident #1. According to the report, the client hit her head on the dresser drawer and sustained a laceration to the head. DOH/HRLA was notified on June 14, 2011 at 11:00 a.m. via fax.</p> <p>During a face to face interview with the RC/ IMC on June 23, 2011 at approximately 1:00 p.m., she stated " I faxed the report late."</p> <p>There was no documented evidence the DOH/HRLA was notified within 24 hours.</p> <p>6. On June 23, 2011, a record review of Resident#1's record at approximately 12:00 p.m. revealed the following:</p> <p>a). A nursing note dated December 26, 2010 with the time of 4:30 p.m., documented "staff reported scratch mark on individual's right eye brow."</p> <p>b). A nursing note dated February 12, 2011 with</p>	I 379	<p>6. Volunteers of America Chesapeake, Inc/DC Community Living Centers and the RN supervisor will ensure that nurses are trained to require an incident report form from any employees that report an injury to the Nurse, before leaving the home. Afterwards, Nurses will report incident to RN, verify via staff that IMC has been notified, and document treatment on incident report and in nursing notes before leaving home. In addition QMRP's will as a standard practice, review monthly notes and nursing notes on a more requent basis (i.e. weekly).</p>	7/22/11	

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1379	Continued From page 5 the time of 9:00 a.m., documented "Bruise mark of unknown origin noted on individual forehead" During a face to face interview with the RC/IMC on June 23, 2011 at approximately 1:00 p.m., she indicated that she was not made aware of those incident's . There was no documented evidence the DOH/HRLA was notified of the aforementioned injuries of unknown origin within 24 hours.	1379		
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District laws that govern the care and rights of persons with mental retardation, for one resident residing in the facility. (Resident #4) The finding includes: (Chapter 13, § 7-1305.10) The GHPID failed to demonstrate protection of Resident #4's right to be free from the use of restraints during the administration of her	1500		

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1500	Continued From page 6 medication as evidenced below: Observation of the administration of the medication pass on June 23, 2011 at approximately 9:06 a.m. revealed the Licensed Practical Nurse (LPN) preparing to administer Resident #4's medication. The LPN informed the surveyor that she had to take the resident's blood pressure before administering her medication. Further observation revealed the LPN verbally prompted the resident to sit in the facility's weight chair. The LPN was observed to stand in front of the resident and when she attempted to place the blood pressure cup on the resident's arm, she refused to be still. It should be noted that the LPN was observed to be straddled over the resident and had the direct care staff hold Resident #4's left arm while she held the right arm with the blood pressure cup. Resident #4 kept attempting to get up from the chair, but the LPN continued to hold the resident in place preventing her from moving. The LPN was unable to hold the resident in a still position and she was observed to break away. At approximately 9:20 a.m. another attempt was made by the LPN to take the resident's blood pressure. The same positioning of the LPN was observed with her straddled over Resident #4 in the weight chair making another attempt to get the resident's blood pressure. The LPN announced that she had been successful this time in getting Resident #4's blood pressure. The GHPID failed to demonstrate protection of Resident #4's right to be free from the use of restraints during the administration of her medication.	1500	1500 Volunteers of America Chesapeake, Inc/DC Community Living Centers and the RN supervisor will ensure that nurses are trained on how to manage, document and implement appropriate procedures for refusal of medication and or treatment. Procedures for refusal will be adhered to by all nursing staff. RN will implement a system for monitoring medication pass at least quarterly per nurse and will provide documentation of concerns to Program Director/Director of Operations with appropriate action plan for correcting concerns when applicable.	7/22/11