

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2009
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NAME OF PROVIDER OR SUPPLIER  CENTER FOR SOCIAL CHANGE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE WASHINGTON, DC 20018
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{1 000}	<p><b>INITIAL COMMENTS</b></p> <p>A follow-up licensure survey was conducted on January 5, 2009, to verify compliance with the regulations cited during the initial licensure survey on October 15, 2008. The survey findings were based on observations, interview with the Program Coordinator (PC), and review of the GHRMP's unusual incident management system, including unusual incident reports.</p> <p>The findings of the survey determined that previously cited deficient practices remained unabated as evidenced throughout the following report.</p>	{1 000}		
{1 090}	<p><b>3504.1 HOUSEKEEPING</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that the residence was maintained in a safe, clean, attractive and sanitary manner.</p> <p>The findings include:</p> <p>Observations during the environmental walk through on January 5, 2008 at approximately 12:10 PM revealed the following:</p> <ol style="list-style-type: none"> <li>1. The basement ceiling was observed with water damage.</li> <li>2. A large hole was observed in the basement</li> </ol>	{1 090}	<ol style="list-style-type: none"> <li>1. The ceiling tile with water damage is replaced</li> <li>2. The ceiling tile over the wash machine is also replaced.</li> </ol>	<p>1-16-09</p> <p>1-16-09</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD 12-0050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  IN 01/05/2009
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{1 090}	<p>Continued From page 1</p> <p>ceiling tile located directly above the washing machine that exposed pipes. Interview with the Program Coordinator (PC) revealed that one resident was capable of using the washing machine.</p> <p>*****</p> <p>Previously cited deficient practice on October 15, 2008.</p> <p>Based on observation and interview, the GHMRP failed to ensure that the residence was maintained in safe, clean, attractive and sanitary manner and free from an accumulation of dirt.</p> <p>The findings include:</p> <p>Internal</p> <ol style="list-style-type: none"> <li>1. There was no trash can in the kitchen.</li> <li>2. A large crack was observed on the wall in the medication room.</li> <li>3. The light fixtures in bedroom #4 and the adjacent dressing room was without any working lights fixtures.</li> <li>4. The floor in the adjacent dressing room floor was sunken and was bowed in the middle of the floor.</li> <li>5. The kitchen and dining room floors were damaged and in need of repair.</li> <li>6. The basement ceiling was observed with water damage.</li> <li>7. The basement floor area had a large crack in the concrete foundation.</li> </ol>	{1 090}	<ol style="list-style-type: none"> <li>1. Trash can purchased and in use</li> <li>2. The wall was repaired</li> <li>3. The Light fixture was repaired</li> <li>4. The floor in this room has been repaired</li> <li>5. Kitchen repair schedule</li> <li>6. Water damage to basement ceiling</li> <li>7. Basement floor was repaired</li> </ol>	<p>10-22-08</p> <p>10-17-08</p> <p>10-17-08</p> <p>11-05-08</p> <p>1-5-09</p> <p>11-04-08</p> <p>11-04-08</p>

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(000)	<p>8. The freezer located in the basement did not have a thermometer.</p> <p>External</p> <p>The wheelchair ramp in the rear of the residence was observed to have several loose and warped planks at the end of the ramp. Additionally, the railing supports had missing nails.</p>	(000)	<p>8. Thermometer placed in Freezer</p> <p>Wheel chair access ramp repaired</p>	<p>10-31-08</p> <p>11-05-08</p>
(095)	<p>3504.6 HOUSEKEEPING</p> <p>Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that caustic agents were stored in a locked area.</p> <p>The findings include:</p> <p>Observation during the environmental walk-through on January 5, 2009 at 10:30 AM revealed the following:</p> <p>1. Bathroom #1 located on the first level beside the kitchen was observed with Lysol bathroom cleaner, disinfectant spray, and Power House bathroom cleaner stored underneath the cabinet.</p> <p>2. Bathroom #2 located in the main hallway on the second level was observed with two (2) cans of disinfectant spray stored underneath the cabinet.</p> <p>***** Previously cited deficient practice on October 15,</p>	(095)	<p>1. Staff re-trained on placement of cleaning supplies Lysol bathroom cleaner, disinfect spray, power house bathroom cleaner and all other cleaning supplies from the bathroom and storage in locked closet only.</p> <p>2. Staff re-trained on placement of cleaning supplies Lysol bathroom cleaner, disinfect spray, power house bathroom cleaner and all other cleaning supplies from the bathroom and storage in locked closet only.</p>	<p>1-6-09</p> <p>1-6-09</p>

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{I 095}	Continued From page 3  2008.  Based on observation, the GHMRP failed to ensure that caustic agents were stored in a locked area.  The findings include:  Observation during an environmental walk-through on 10/15/08 at 12:40 PM revealed that laundry cleaning supplies (i.e. detergent, Clorox, etc.) were being stored in the laundry room unlocked.	{I 095}	Lock purchased and placed on the cabinet keeping bleach and soap of Individuals direct reach	10-16-08
{I 203}	3509.3 PERSONNEL POLICIES  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment.  The finding includes:  On January 5, 2009 at approximately 12:40 PM, interview with the Program Coordinator (PC) revealed that there were twelve (12) direct care staff employed by the facility. Further interview with the PC revealed that all personnel records were at the main office. When asked by the surveyor if someone from the main office could bring the records, the PC stated that there was no one at the main office to transport the records to the facility- At the time of the survey, the facility failed to provide evidence that the	{I 203}	It is the Center for Social Change Policy to review job descriptions with all employees at the beginning of employment and at least annually thereafter. These files were reviewed by HRA incident monitors 1-16-09. The Center for Social Change will ensure that upon DOH request someone from the main office will escort employee records from the main office	1-5-09

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{1203}	Continued From page 4 supervisor discussed the contents of job descriptions with each employee at the beginning of their employment.  ***** ***** Previously cited deficient practice on October 15, 2008.  Based on personnel records review, the GHMRP failed to have on file at the beginning of employment job descriptions for all employees.  The finding includes:  Review of the personnel files conducted on 10/15/08 revealed that GHMRP failed to provide evidence of current signed job descriptions for eight (8) newly employed direct care staff. (Staff #1 - #8)	{1203}		
{1206}	<b>3509.6 PERSONNEL POLICIES</b>  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 staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings.  The finding includoc:	{1206}	Each person in the home has a signed job description	11-12-08

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{ 206}	<p>Continued From page 5</p> <p>On January 5, 2009 at approximately 12:40 PM, interview with the Program Coordinator (PC) revealed that there were twelve (12) direct care staff employed by the facility. Further interview with the PC revealed that all personnel records were at the main office. When asked by the surveyor if someone from the main office could bring the records, the PC stated that there was no one at the main office to transport the records to the facility. At the time of the survey, the facility failed to provide evidence that all staff received annual health screenings as required.</p> <p>***** *****</p> <p>Previously cited deficient practice on October 15, 2008.</p> <p>Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section.</p> <p>The findings include:</p> <p>Interview with the QMRP and review of the available personnel records on October 15, 2008 revealed the GHMRP failed to provide evidence of physical examinations for the QMRP, the primary care physician, the medication nurse, and the Director of Nursing. In addition, there was no evidence of health certification's for eight direct care staff (Staff #1 - #8).</p>	{ 206}	<p>It is the Center for Social Change Policy to update health certificates annually with all employees at the beginning of employment and at least annually thereafter. These files were reviewed by HRA incident monitors 1-16-09. The Center for Social Change will ensure that upon DOH request someone from the main office will escort employee records from the main office</p> <p>All staff will have a signed health certification or be removed from their shift by</p> <p>All Clinical Consultants and Clinical Staff will have health Certification on file.</p>	<p>1-5-09</p> <p>11-13-08</p> <p>11-14-08</p>
I 261	<p>3512.2 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record shall be kept in a centralized file and made available at all times for inspection and</p>	I 261		

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I 261	Continued From page 6  review by personnel of authorized regulatory agencies.  This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure records were available for inspection at all times by personnel of authorized regulatory agencies.  The finding includes:  On January 5, 2009 at approximately 12:40 PM, interview with the Program Coordinator (PC) revealed that there were twelve (12) direct care staff employed by the facility. Further interview with the PC revealed that all personnel records were at the main office. When asked by the surveyor if someone from the main office could bring the records, the PC stated that there was no one at the main office to transport the records to the facility. At the time of the survey, the facility failed to ensure the availability of records for review during inspection.	I 261		
{ 274 }	3513.1(e) ADMINISTRATIVE RECORDS  Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:  (e) Signed agreements or contracts for professional services;  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services.  The finding includes:	{ 274 }	It is the Center for Social Change Policy to maintain employee records at our central office located 6600 Amberton Drive Elkridge Md. These files were reviewed by HRA incident monitors 1-16-09. The Center for Social Change will ensure that upon DOH request someone from the main office will escort employee records from the main office	1-5-09

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{1 274}	Continued From page 7  On January 5, 2009 at approximately 12:40 PM, interview with the Program Coordinator (PC) revealed that there were twelve (12) direct care staff employed by the facility. Further interview with the PC revealed that all personnel records were at the main office. When asked by the surveyor if someone from the main office could bring the records, the PC stated that there was no one at the main office to transport the records to the facility. At the time of the survey, the facility failed to provide evidence of signed agreement or contracts with each consultant providing professional services.  ***** ***** Previously cited deficient practice on October 15, 2008.  Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services.  The findings include:  Interview with the Qualified Mental Retardation Professional and review of personnel records on 10/15/08 revealed no evidence that the GHMRP had entered into written agreements or contracts with the consulting physician, Medication Nurse, and Director of Nursing.	{1 274}	It is the Center for Social Change Policy to maintain consultant records at our central office located at 6600 Amberton Drive Elkridge Md. These files were reviewed by HRA incident monitors 1-16-09. The Center for Social Change will ensure that upon DOH request someone from the main office will escort employee records from the main office        All Consultant contract will be signed	1-5-09        11-15-08
{1 371}	3519.2 EMERGENCIES  Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section.	{1 371}		

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(1371)	Continued From page 8  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to train the staff on the agency's emergency policies and procedures.  The finding includes:  On January 5, 2008 at 12:50 PM, interview with the Program Coordinator (PC) and review of the in service training records revealed that four (4) of twelve (12) direct care staff had received training on the agency's emergency policies and procedures.  ***** ***** Previously cited deficient practice on October 15, 2008.  Based on interview and record review, the GHMRP failed to train the staff on the agency's emergency policies and procedures.  The finding includes:  On October 15, 2008 at approximately 10.30 AM, interview with the QMRP and the review of the available training records revealed that the GHMRP failed to provide evidence that direct care staff had been trained on the agency's emergency policies and procedures.	(1371)	Staff training is on going all staff will receive safety training by  Staff training on Emergency Protocol procedures scheduled and completed	1-27-09  11-13-08
1379	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	1379		

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1379	<p>Continued From page 9</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the six residents that resided in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on January 5, 2009 at 9:20 AM revealed no evidence of unusual incidents since the initial licensure survey conducted on October 15, 2008. Interview with the Program Coordinator (PC) on the same day at approximately 11:45 AM revealed that Resident #1 was abused verbally/physically by Direct Care Staff #1 in November 2008 while on a medical appointment. Further interview with the PC revealed that he notified the DOH of the incident, however, was not able to produce any evidence. At the time of the survey, the GHMRP failed to ensure that the DOH was notified of the allegation of abuse as required.</p>	1379	<p>The incident that occurred in the community on 11-18-08 was reported to family, attorney, DDS service coordinator, Answers please, it was told to the DC Coordinator by then Supervisor that it was recorded to HRA and placed in DDS MCIS system a copy of this report will be forwarded with this plan of correction. The CSC has also requested a new MCIS access code to report incidents.</p>	1-12-09
1500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this</p>	1500		

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I 500	<p>Continued From page 10 chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137 (Rights of Mentally Retarded Citizens), this chapter, and other applicable District and Federal Laws.</p> <p>The findings include:</p> <p>Interview and the record review during the follow-up visit on January 5, 2009 revealed the following concerns:</p> <p>The facility failed to ensure residents' rights as described in §7-1305.10. (Mistreatment, neglect or abuse prohibited) and as detailed below:</p> <p>Review of the facility's incident reports on January 5, 2009 at 9:20 AM revealed no evidence of unusual incidents since the initial licensure survey conducted on October 15, 2008. Interview with the Program Coordinator (PC) on the same day at approximately 11:45 AM revealed that Resident #1 was abused verbally/physically by Direct Care Staff #1 in November 2008 while on a medical appointment. Further interview with the PC revealed that the allegation of abuse was investigated and all pertinent parties (ie, family/guardian, the facility director, and attorney) were notified. At the time of the survey, however, there was no evidence provided to verify that an investigation and the required notifications were conducted.</p>	I 500	<p>The incident that occurred in the community on 11-18-08 was reported to family, attorney, DDS service coordinator, Answers please, it was told to the DC Coordinator by then Supervisor that it was recorded to HRA and placed in DDS MCIS system a copy of this report will be forwarded with this plan of correction. The CSC has also requested a new MCIS access code to report incidents.</p>	1-12-09

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R 000	<p><b>INITIAL COMMENTS</b></p> <p>A follow-up licensure survey was conducted on January 5, 2009, to verify compliance with the regulations cited during the initial licensure survey on October 15, 2008. The survey findings were based on observations, interview with the Program Coordinator (PC), and review of the GHRMP's unusual incident management system, including unusual incident reports.</p> <p>The findings of the survey determined that previously cited deficient practices remained unabated as evidenced throughout the following report.</p>	R 000		
R 125	<p><b>4701.5 BACKGROUND CHECK REQUIREMENT</b></p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.</p> <p>The finding includes:</p> <p>On January 5, 2009 at approximately 12:30 PM, interview with the Program Coordinator (PC) revealed that there were twelve (12) direct care staff employed by the facility. Further interview with the PC revealed that all personnel records were at the main office. When asked by the</p>	R 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	(X6) DATE
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PRINTED: 01/14/2009  
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2009
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NAME OF PROVIDER OR SUPPLIER  CENTER FOR SOCIAL CHANGE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE WASHINGTON, DC 20018
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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) COMPLETE DATE
R 125	Continued From page 1  surveyor if someone from the main office could bring the records, the PC stated that there was no one at the main office to transport the records to the facility. At the time of the survey, the facility failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for 12 staff employed staff.	R 125	It is the Center for Social Change Policy does a national criminal background check on all employees. These records are kept at our central office located at 660 Amberton Drive Elkridge Md. These files were reviewed by HRA incident monitors 1-16-09. The Center for Social Change will ensure that upon DOH request someone from the main office will escort employee records from the main office	1-5-09