STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G027	A. BUILDING _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 24, 2013 to September 27, 2013. A sample of two clients was selected from a population of four females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	Received 10/18/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body failed to have an effective system to ensure the timely procurement of a medication that required prior authorization, for one of two clients in the sample. (Client #1) The finding includes: On September 24, 2013, at 7:56 p.m., trained medication employee (TME) #1 was observed to administer Client #1 Calcium W/V 600 mg/400 tablet by mouth.	W 104		

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

Director Health Svcs 10/17/13

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

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W 104	Continued From page 1 Interview with TME #1 on September 24, 2013, at 8:03 p.m. revealed that Client #1 was prescribed to receive Calcium W/V 600 mg/400 tablet in the morning and evening. Additionally, the client was prescribed to receive several other medications in the morning. On September 24, 2013, at 8:29 p.m., verification of the medication administration record (MAR) and the corresponding physician's orders, confirmed Client #1 was prescribed Calcium W/V 600 mg/400 tablet in the morning and evening for bone health. The MAR and the physician's revealed the client was prescribed Tyzeka F/C 600 mg tablet, 1 tablet by mouth every morning for chronic hepatitis B. Further review of the MAR revealed however, that Client #1 did not receive Tyzeka F/C 600 mg tablet, on September 14, and September 15, 2013 because it was not available. Interview with primary registered nurse (RN) #1 on September 27, 2013 at 11:40 a.m., confirmed that Client #1 did not receive the Tyzeka F/C 600 mg tablet medication as prescribed on the aforementioned dates, because the pharmacy did not deliver it on time. Primary RN #1 indicated that although the facility made efforts to correct the problem in the past, it remained a concern. [Note: The MAR revealed that the client also did not receive this medication on May 12, 13, 14, and 15, 2013 because it was not available.] On September 27, 2013, at 11:51 p.m., interview with the director of nursing (DON) revealed that in both instances the pharmacy reported that the delivery of the Tyzeka F/C 600 mg tablets was delayed because prior approval was not obtained	W 104	**W104 Governing Body** The QIDP in conjunction with the RN will ensure that an effective system are in place for the timely procurement of medications that requires prior authorization before the release of the medication by the facility by establishing a written protocol by 11/01/13. The RN will review and monitor medication on a monthly basis to ensure compliance.	11/01/13 Ongoing

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W 104	Continued From page 2 to renew the prescriptions. According to the DON, the pharmacy did not notify the agency of the expiration dates of authorizations to purchase the medication. The DON revealed that this notification would alert the agency to request a timely updated authorization from the funding source, to ensure the client received the medication as prescribed. The DON indicated that the agency is continuing to investigate the problem in order to develop an effective system to ensure timely notification when prior authorization for medication is required. At the time of the survey, there was no evidence an effective system had been implemented to ensure the timely provision of each medication requiring prior authorization before the release of the medication to the facility.	W 104		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all drugs and biological were kept locked, except when being prepared for administration for three of four clients in the sample (Clients #1, #3, and #4). The finding includes: On September 24, 2013, at 7:10 p.m., trained medication employee (TME) #1 announced to the surveyor that she was ready to administer the	W 382	**W382 Drug Storage and Recordkeeping** The QIDP/Program Manager in conjunction with the RN will ensure that all drugs and biological are kept locked, except when being prepared for administration by in-service all staff on medication management by 11/01/13. The RN will continue to observe staff on a quarterly basis to ensure compliance. The staff involved has received additional training on safe guarding medications during the administration process. In addition the staff involved will be monitored during the delivery of medication for a period of once a week, 3 consecutive weeks until they demonstrate error free sessions.	10/15/13 Ongoing

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W 382	Continued From page 3 clients' evening medications. At 7:27 p.m., TME #1 was observed to administer Client #4 medications that included: Atorvastin Calcium 80 milligrams (mg.) tablet; Calcium w/v 600 mg.- 400 mg. tablet; Carbamazepine 200 mg. tablet; Folic Acid 0.4 mg. tablet, 2 tablets (.8 mg.); Trihexyphendyl HCl 2 mg. tablet; and Zetia U-D 10 mg. tablet. At 7:35 p.m., TME #1 left the medication closet open and escorted Client #4 back to the living room. After the clients' medications were administered, the closet remained open while the TME escorted the clients from the medication area to the living room. Interview with TME #1 on September 24, 2013, at 8:29 p.m., and with primary registered nurse (RN) #1 on September 25, 2013, at 2:37 p.m., confirmed that the medication closet should be locked at all time except when medications are being prepared for administration.	W 382		

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	HFD03-0238	A. BUILDING: _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 24, 2013 to September 27, 2013. A sample of two residents was selected from a population of four females with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and one day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each bedroom was equipped with a nightstand for each resident in the bedroom of two residents. (Residents #1 and #3) The finding includes: Observation of the bedroom of Residents #1 and #3 on September 26, 2013, at 3:47 p.m., revealed one nightstand placed between the beds of the	I 075	**I075 Bedrooms and Bathrooms** Each bedroom shall be equipped with at least the following items (d) Night stand 1. The QIDP/Program Manager will ordered a night stand. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and repaired/replaced as needed.	11/01/13 Ongoing

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I 075	Continued From page 1 residents. Interview with facility's program director (PD) #1 during the observation on September 26, 2013, at 3:37 p.m., confirmed there was only one night stand for the bedroom. At the time of the survey, the facility failed to ensure that a nightstand was provided as required for the use of each client in their bedroom. [This is a repeat deficiency.]	I 075		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, and interview, the group home for individuals with intellectual disabilities (GHIID) failed to maintain the environment in accordance with the needs of four of four residents of the facility. (Residents #1, #2, #3, and #4. The findings include: On September 26, 2013, at 3:02 p.m., the facility's coordinator (FC) #1 accompanied the surveyor to conduct an inspection of the environment. The following concerns were identified:	I 090		

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I 090	Continued From page 2 A. Exterior 1. The bench located adjacent to the steps leading to the front porch partially obstructed the left railing on the steps. The frame of the bench was not tightened securely, which caused mobility when pressure was applied. These concerns presented potential safety hazards. 2. The roof was positioned several inches above the gutter installed at the back of the facility, creating a potential for water entering the wall. B. Interior 1. Observation of the ceilings and walls revealed there was evidence of moisture damage in the following areas: a. In Resident #4's bedroom, there were several areas of scaling paint and unpainted surface near the baseboard. There was a crack in the wall from the top of the window to the ceiling. In the same area, the ceiling was slightly warped. Additionally, there was a large open hole in the wall of the closet, which had been cut to expose the plumbing pipes. b. There was a hole in the wall at the ceiling to wall junction of the laundry room. Also, in the laundry room, there was a large, wide, heavily stained area on the wall going downward from the ceiling to as far as was visible behind the washer. 2. The handle for opening the bottom drawer of the range was broken off. 3. Both bath tubs in the facility had a gray substance on the interior bottom. Interview with	I 090	**I 090- Housekeeping** The exterior and exterior of each the home shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. A. Exterior 1. The bench located adjacent to the steps leading to the front porch that partially obstructed the left railing on the steps has been removed on 10/15/13 from the premise to prevent potential safety hazards. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary. 2. The roof lining that was positioned several inches above the gutter installed at the back of the facility that created a potential for water entering the wall will be replaced by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary. B. Interior 1. Evidence of moisture damage in the following area will be repaired by11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary.	11/01/13 Ongoing 11/01/13 Ongoing 11/01/13 Ongoing 11/01/13

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I 090	Continued From page 3 the facility's program coordinator indicated that the tubs had been thoroughly cleaned and the gray substance could not be removed. Rust was observed at the edges of the drains of the tubs. 4. The lining underneath Resident #4 lamp shade was loose and hanging, creating a potential safety hazard. 5. The handle necessary to open the bottom drawer of Client #1's storage chest was missing. The track required to keep the third drawer of Resident #3's chest of drawers properly aligned, when in an open position, was splintered and worn. 6. Rust accumulation was observed on the vent cover beside the commode in the master bathroom. 7. The bottom of the kitchen cabinet located underneath the sink was heavily stained with a dark substance, and could not be easily cleaned. Closer observation of the adjacent corner cabinet revealed it lacked a bottom, causing the floor to be exposed. FC #1 verbally confirmed that the identified concerns were present. FC #1 further stated that the administrative office would be informed of the findings identified during the inspection and that the necessary maintenance would be requested.	I 090	a. In Resident #4 bedroom, the areas of scaling paint and unpainted surface near the baseboard, the crack in the wall from the top of the window to the ceiling , the warped ceiling and the large open hole in the wall of the closet which had been cut to expose the plumbing pipes will be repaired by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary. b, The hole in the wall in the ceiling to the wall junction of the laundry room as well as the large, wide heavily stained area on the wall going downward from the ceiling to behind the washer will be repaired/replaced by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary. 4.. The lining underneath Resident #4 lamp shade that was loose and hanging creating a potential safety hazard was replaced on 10/1/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary.	11/01/13 11/01/13 11/01/13
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status	I 206		

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I 206	Continued From page 4 would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each consultant had a current health certificate for two of ten consultants providing services to the residents (Consultants #1 and #2). The findings include: During the entrance conference on September 24, 2013, at 3:00 p.m., the qualified intellectual disabilities professional (QIDP) was notified of the records required to complete the survey process. Record review on September 25, 2013, at 2:55 p.m., revealed no current health certificates were available for the pharmacist and the psychologist. At that time, the surveyor notified the facility's qualified intellectual disabilities professional (QIDP) of the expired the health certificates. The QIDP stated that the administrative office would be notified to provide the current health certificates if they were available. At the time of the survey, however, current health certificates were not available for the aforementioned consultants.	I 206	5.. The handle necessary to open the bottom drawer of client #1 storage chest that was missing will be repaired/replaced by11/01/13. The track required to keep the third drawer of Resident #3 chest of drawers properly aligned, when in an open position that was splintered and worn will be repaired/ replaced by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary. 6. The rust accumulation on the vent cover beside the commode in the master bathroom will be repaired/ replaced by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repaired/replacing as necessary. 7.. The bottom of the kitchen cabinet located underneath the skink that was heavily stained with a dark substance and the adjacent corner cabinet that lacked a bottom causing the floor to be exposed will be rep[aired/ replaced by 11/01/13. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary. **I206** Ensure that all employees, health care professionals, and consultants have current health certificates. QIDP//Personnel Administrator will ensure that all employees and health care professional have current health certificates including consultants. One of the consultant's certificate was secured by 10/1/13. . Personnel Administrator will perform quarterly monitoring to ensure compliance and adequate notification to employees of upcoming expiration dates.	11/01/13 11/01/13 11/01/13