

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0228	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019
--	---

(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
--------------------	--	---------------	---	--------------------

1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from October 9, 2013 through October 11, 2013. The survey resulted in a determination that the facility was operating in substantial compliance with licensure regulation title 22 Chapter 35.</p> <p>Direct Support Professional - DSP Program Manager-PM Individual Support Plan - ISP</p>	1 000	<p><i>Received 11/6/13</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
-------	--	-------	--	--

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Director Programs</i>	(X6) DATE <i>11/6/13</i>
---	-----------------------------------	-----------------------------

STATE FORM

6899

LHR011

If continuation sheet 1 of 1

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

PRINTED: 10/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019
--	---

(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

W 000

A recertification survey was conducted from October 9, 2013 through October 11, 2013. A sample of three clients was selected from a population of five clients with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations, interviews, and record review.

Note: The below are abbreviations that may appear throughout the body of this report.

Direct Support Professional - DSP
Program Manager- PM
Individual Support Plan - ISP

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.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure each client's adaptive equipment was maintained in good repair, for one of the three clients in the sample that required a shower wheelchair for bathing. (Client #3)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Director Programs

(X5) DATE

10/6/13

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.

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

PRINTED: 10/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2013
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	
(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 436	Continued From page 1 The finding includes: On October 11, 2013, beginning at 3:00 p.m., observations of the facility revealed there was a light blue shower wheelchair located in the bathroom. The condition of the shower wheelchair was observed as following: - The wheels on the shower wheelchair were observed to be rusted. - The screws on the wheelchair were full soap scum and rust. - The commode seat and arm rest padding were observed with several large rips which exposed the cushion. - The back seat cushion was observed with several large rips exposing the inner foam. On October 11, 2013, at approximately 3:45 p.m., interview with DSP #1 revealed that Client #3 used the shower wheelchair for bathing. At 4:00 p.m., interview with the PM revealed that she was not aware that staff were still using the shower chair. The PM revealed that she was not aware that staff were still using the chair when another chair was available for use. On October 11, 2013, at approximately 4:10 p.m., review of Client #3's ISP dated February 11, 2013, revealed the client was prescribed a shower chair for bathing. At the time of the survey, the facility failed to ensure that Client #3's adaptive equipment was maintained in good repair.	W 436	W436 The light blue shower chair that was located in the bathroom during the survey was removed from the property. A new shower chair was purchased placed in the bathroom. To ensure each individual's adaptive equipment is maintained in good repair, QIDP/Program Manager will have equipment inspected daily and documented on the individual's "Adaptive Equipment Form". In cases where equipment is found to be defective, the Director of Nursing will be notified immediately. Repairs/replacements will be made as quickly as possible.	10/11/13 Ongoing