

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

PRINTED: 11/14/2012  
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  10/26/2012
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  A recertification survey was conducted from October 24, 2012 through October 26, 2012. A sample of three clients was selected from a population of five males 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 at 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	<p><i>Received 12/14/12</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met individual's need, for one of the three sampled clients with prescribed adaptive feeding equipment. (Client #3)  The finding includes:  The facility failed to ensure that Client #3's day program used adaptive eating equipment, as evidenced below:	W 120		W120  The QDIP will have a meeting with the day program case manager to determine if the program can meet the dietary protocol of Client #3 which includes the use of adaptive eating equipment and the recommendation of the OT. If it is determined that the day program can not meet his needs, a team meeting will be held with recommendations for him to be transferred to another program. To ensure proper compliance with dietary protocol, QIDP will facilitate necessary training and will monitor day program quarterly. In cases of noncompliance, a team meeting will be held in an effort to resolve problems.

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

TITLE

(X6) DATE

*[Signature]*

*RN Director Health Services 11-20-12*

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 120	Continued From page 1  Observations conducted at the day program on October 24, 2012, at 11:55 a.m., revealed Client #3 was served his lunch meal which consisted of fish, spinach/turnip greens and mash potatoes in a low sided plate with a built up spoon. Continued observations revealed the client had difficulties at times throughout the meal scooping the food up with the spoon and bringing the food to his mouth. Some spillage was observed throughout the lunch meal. Later than evening at approximately 5:50 p.m., dinner observations revealed Client #3 was served his dinner meal on a plate riser. With the use of the plate riser, there was a shorter distance traveled from the plate to Client #3's mouth. The client also remained in a more upright position and there was minimal spillage observed while feeding with the plate riser.  Review of Client #3's record on October 26, 2012, at 9:39 a.m., revealed an occupational assessment (OT) dated February 28, 2012. According to the assessment, the OT recommended the use of the plate riser to reduce the distance from plate to mouth during meals. Further review revealed that plate riser would help him to sit in an upright position.  A telephone interview was conducted with day program staff (DPS1) on October 26, 2012, at approximately 11:10 a.m., to ascertain why a plate riser was not used during lunch time on October 24, 2012. According to DPS1, the plate riser was not being used because the plate riser sat up too high on the table which caused the plate to almost touch Client #3's chin while eating. Continued interview with DPS1 revealed that Client #3 currently was seated at a table which	W 120	

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W 120  W 440	<p>Continued From page 2</p> <p>was the appropriate height for his wheelchair. Interview with the qualified intellectual disabilities professional (QIDP) on October 26, 2012, at approximately 2:30 p.m., revealed that the plate riser should be used, as prescribed.</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for five of five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On October 24, 2012, at 3:01 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed there were five (5) designated shifts (6:30 a.m. - 2:30 p.m.; 2:30 p.m. - 11:00 p.m.; and 11:00 p.m. - 9:30 a.m.) and two designated weekend shifts (9:00 a.m. - 11:00 p.m. and 11:00 p.m. - 9:00 a.m. for Saturday/Sunday.</p> <p>Review of the facility's fire drill log records on October 24, 2012, beginning at approximately 3:10 p.m., revealed that no drills were held during the weekday first and second shift (6:30 p.m. - 2:30 p.m. and 2:30 p.m. - 11:00 p.m.) from October 2011 through December 2011. Further</p>	W 120  W 440	<p>W440</p> <p>The QIDP/Program Manager will monitor and review fire drill records monthly to ensure that fire drills are conducted at least four (4) times a year for each shift of personnel. In cases of noncompliance, QIDP/Manager will request that staff conduct a drill within 24 hours on the respective shift.</p> <p>11/30/12 Ongoing</p>



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W 448	Continued From page 4 due to his cerebral palsy and spastic hemiplegia.  Review of the fire evacuation drills from the period October 2011 through October 2012 was conducted on October 24, 2012, beginning at 3:10 p.m. During the second shift (11:00 p.m. - 9:30 a.m.), staff documented as having evacuated all five clients on an average of two and half minutes during the aforementioned time period.  The qualified intellectual disabilities professional (QIDP), house manager (HM) and the director of health services (DHS) were interviewed on October 24, 2012, at 3:40 p.m. and October 26, 2012, at approximately 4:00 p.m., respectively. When mentioned that the second shift fire drills took on an average of two and a half minutes, they (QIDPP, HM and DHS) all stated that it was highly impossible to evacuate 5 clients with only 2 staff persons. When further queried to ascertain if the problem had been investigated, the HM failed to be able to provide information and/or documented evidence that the issue had been addressed.  At the time of the survey, the facility failed to provide evidence that problems associated with evacuation drills were addressed.	W 448	

Health Regulation & Licensing Administration

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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from October 24, 2012 through October 26, 2012. A sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this 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 group home for persons with intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observation, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>Observation during the inspection of the environment on October 26, 2012, beginning at</p>	1 090	<p>1090</p> <p>The QIDP/Program Manager will have the outside hole in the upper corner of the front of the house repaired. QIDP/Program Manager will perform monthly QA of the outside and inside of the residence to identify repair needs and make the prompt repairs as necessary.</p>	<p>11/30/12 Ongoing</p>

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

STATE FORM

6896

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If continuation sheet 1 of 4

Health Regulation & Licensing Administration

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I 090	Continued From page 1  2:45 p.m., revealed there was a hole located in the upper corner of the front of the house. The hole appeared to be large enough for a small animal (raccoon, squirrel, etc.) to go through. The house manager (HM) who was present during the inspection confirmed the above aforementioned finding.	I 090	
I 135	3505.5 FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for five of the five residents residing in the GHPID. (Residents #1, #2, #3, #4 and #5)  The finding includes:  The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On October 24, 2012, at 3:01 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed there were five (5) designated shifts (6:30 a.m. - 2:30 p.m.; 2:30 p.m. - 11:00 p.m.; and 11:00 p.m. - 9:30 a.m.) and two designated weekend shifts (9:00 a.m. - 11:00 p.m. and 11:00 p.m. - 9:00 a.m. for Saturday/Sunday.  Review of the GHPID's fire drill log records on October 24, 2012, beginning at approximately 3:10 p.m., revealed that no drills were held during	I 135	I135  The QIDP/Program Manager will monitor and review fire drill records monthly to ensure that fire drills are conducted at least four (4) times a year for each shift of personnel. In cases of noncompliance, QIDP/Manager will request that staff conduct a drill within 24 hours on the respective shift  -----  11/30/12 Ongoing

Health Regulation & Licensing Administration

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I 135	Continued From page 2  the weekday first and second shift (6:30 p.m. - 2:30 p.m. and 2:30 p.m. - 11:00 p.m.) from October 2011 through December 2011. Further review revealed there were no drills held during the weekend first shift (9 a.m. - 11:00 a.m.) from January 2012 through March 2012 and from July 2012 through September 2012.  On October 26, 2012, at approximately 4:00 p.m. interview with the house manager (HM) confirmed that fire drills were not conducted on the weekday first and second shift and on the weekend first shift.	I 135		
I 206	<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 interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates on file, for 2 of 7 consultants. (Consultants #4 and #7)  The findings include:  On October 26, 2012, beginning at 1:10 p.m., review of the personnel records for all employees, including licensed professional health consultants, revealed C4 and C7 health	I 206	<b>I206</b> The outstanding health certificates for the all staff and consultants have been secured and placed on file in their health records in the administrative office  My Own Place Human Resource Department and Director of Health Services will ensure that all staff and consultants 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. In cases when staff are not in compliance, they will be placed on administrative leave until compliance is achieved. Additionally, random quality assurance monitoring of personnel files quarterly to ensure compliance.	11/30/12 Ongoing

Health Regulation & Licensing Administration

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I 206	Continued From page 3  inventory/certificate had expired at the time of the survey. At approximately 1:45 p.m., the director of health services #1 (DHS1), who had facilitated the review, confirmed the aforementioned findings. No additional information was made available for review before the survey ended later that day a approximately 4:30 p.m.	I 206		
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