PRINTED: 12/04/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING 11/22/2013 R WING 09G242 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 431 53RD STREET, SE **VOLUNTEERS OF AMERICA** WASHINGTON, DC 20019 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) W 000 W 000 INITIAL COMMENTS A recertification survey was conducted from November 20, 2013 through November 22, 2013. A sample of three clients was selected from a population of five females with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations, interviews with direct support staff, nursing and administrative staff, as well as a review of clients' medical and habilitation records and the facility's administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional -OIDP Registered Nurse - RN Range of Motion - ROM 483.420(b)(1)(i) CLIENT FINANCES W 140 W 140 The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by:

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

Event ID: PF7G11

Facility ID: 09G242

TITLE

If continuation sheet Page 1 of 8

(X6) DATE

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 12/04/2013 FORMAPPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			DIVID INC	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		09G242	B. WING_	2010-11-11-11-11-11-11-11-11-11-11-11-11-	11/	22/2013
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1	431 53RD STREET, SE		
VOLUNT	EERS OF AMERICA			WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 159	Continued From parthe finding includes Cross-refer to W24 Client #3's communimplemented at the below:  During client observed 2013, Client #3 arrivat 3:50 p.m. The clifacility in a custom-surveyor verbally gradid not respond. At DSP #2 informed the non-verbal. At 3:58 how was her day at respond. At approximately the client did not respond to the client did not respond. At approximately the client did not respond to the cli	ge 2 s: 9. The QIDP failed to ensure nication devices was day program, as evidenced vations on November 20, wed home from day program ient was escorted inside the molded wheelchair. The eeted the client, but the client approximately 3:55 p.m., he surveyor that Client #3 was p.m., DSP #1 asked the client school. The client did not imately 4:00 p.m., DSP #1 with water as part of her, DSP #1 was observed during dinner; however, the nd. At 7:02 p.m., DSP #1 #3 to press the keys on the e client did not respond.  Its ISP records on October 28, tely 2:22 p.m., revealed an	W 15	DEFICIENCY)	that all place for e. VOAC and ne ure they order. bugh tive twe programs per use,	
e e e e e e e e e e e e e e e e e e e	at approximately 1:0 #3 was non-verbal a device that should b stated that the com-	00 p.m., revealed that Client and had a communication be used daily. The QIDP munication device was only to a and not at the client's day				

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Event ID: PF7G11

Facility ID: 09G242

If continuation sheet Page 3 of 8

Connecture, State Dueston 12/12/13

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

PRINTED: 12/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		09G242	B. WING			11/	22/2013
Section 2012 and the section of the	PROVIDER OR SUPPLIER	*		43	REET ADDRESS, CITY, STATE, ZIP CODE 1 53RD STREET, SE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	As soon as the inte formulated a client's each client must re- treatment program interventions and so and frequency to su	ge 3 GRAM IMPLEMENTATION  rdisciplinary team has sindividual program plan, belive a continuous active consisting of needed ervices in sufficient number apport the achievement of the lin the individual program	W 2 W 2	V0.00.00	<b>W 249</b> See also W159		
	Based on observat review, the facility stactile communicati device were made a clients in the sample. The findings included 1. The facility failed communication box opportunity, as evid. On November 20, 2 who was visually imbeing assisted with assisted the client band placing the spoclient was then observation. On November 21, 2 review of Client #1's 2013, revealed the	to ensure Client #1's tactile was presented at every			The assigned QIDP and RC will er staff members are trained on all individuals IPP goals to ensure primplementation of goals to ensure compliance. VOAC will ensure the devices are available and easily lefor use by the individuals and also reference data sheets with IPP goensure consistency in implement. By 12/20/13	oper re at all ocated o cross oals to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PF7G11

Facility ID: 09G242

If continuation sheet Page 4 of 8



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/04/2013 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ÇLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION		TE SURVEY MPLETED
		09G242	B. WING	-		11	/22/2013
NAME OF F	PROVIDER OR SUPPLIER	<b></b>		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	131 53RD STREET, SE		
VOLUNT	EERS OF AMERICA			V	WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
14/ 040	A		10/	249			•
VV 249	Continued From pa			243			1
	dinner, one time a Further review of the following steps:	day, Monday thru Friday. ne program revealed the	The same of the sa				***************************************
	- Staff will say <clie will allow you to che drink with.</clie 	ent name>, we have a box that cose what you need to eat and	Activities of the control of the con				Transfer de la constitución de l
	she may feel the re	er hand in the empty box so that ectangle-shaped area and the eas before placing items in	Berlingen (plantiske) in Albentaute (stern)				
	- One at a time starexplore the box and	ff will allow <client name=""> to d its shape, etc.</client>					( Proposition of the control of the
	that you eat with in can find your spoor	y, I am going to put your spoon side the box. Let's see if you n. Staff will gently place the general area and allow her to					
	out of the box, staff Staff will then say,	e spoon and take the spoon f will provide verbal praise. <client name="">, its dinner time. would be repeated for the cup.</client>					
	approximately 4:10	#4 on November 21, 2013, at pm., confirmed that Client #1					A constraint of the second
-	box prior to dinner	se a tactile communication five days a week. DSP #4					
		s to present the box to the	÷ ) = 1		TO STATE OF THE ST		
		ge her to reach inside the box	To an in the latest and the latest a		*		
		spoon. DSP #4 further stated					
		as not implemented on	Ī				
		3, prior to dinner. The QIDP					
		November 22, 2013, at					
		5 p.m., to ascertain					

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Event ID: PE7G1

Facility ID: 09G242

If continuation sheet Page 5 of 8

Connei Parce, State Director 12/12/13

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

PRINTED: 12/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	•	(X3) DATE SURVEY COMPLETED	
		09G242	B. WING		- 	11/3	22/2013
A Color Action and A Color	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 431 53RD STREET, SE WASHINGTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
W 249	When asked to see could not locate the 2. The facility failed communication dev opportunity, as evid During client observed 2013, Client #3 arrivat 3:50 p.m. The clifacility in a custom-surveyor verbally gradid not respond. At DSP #2 informed the non-verbal. At 3:58 how was her day at respond. At approxiprovided Client #3 we snack. At 5:32 p.m. talking to the client client did not respondencouraged Client #keyboard. Again, the	the tactile box, the QIDP box inside the facility.  I to ensure Client 3's ice was implemented at every enced below:  rations on November 20, red home from day program ent was escorted inside the molded wheelchair. The eeted the client, but the client approximately 3:55 p.m., e surveyor that Client #3 was p.m., DSP #1 asked the client school. The client did not mately 4:00 p.m., DSP #1 with water as part of her , DSP #1 was observed during dinner; however, the ad. At 7:02 p.m., DSP #1 f3 to press the keys on the e client did not respond.	W 2	49		8	
HELIO COMPANIA COMPAN	2013, at approximat objective for <cli>client discriminate/choose four Icon voice device</cli>	s ISP records on October 28, tely 2:22 p.m., revealed an name> to visually a leisure time activity using a ce one time daily (Monday - ve consecutive trials.					
The state of the s	at approximately 1:0 #3 was non-verbal a device that should b stated that the com- be used in the home program. When as	IDP on November 22, 2013, 20 p.m., revealed that Client and had a communication be used daily. The QIDP munication device was only to and not at the client's day ked, the QIDP presented the ion device to the surveyor.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PF7G11

Facility ID: 09G242

If continuation sheet Page 6 of 8

Corne Prae, State Director 12/12/12

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

PRINTED: 12/04/2013 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR MEDICARE	WILDIONIS CENTICES	1400 1411	CIDLE (	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Comments of the second		CONSTRUCTION		PLETED
		09G242	B. WING			11/2	2/2013
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					53RD STREET, SE		
VOLUNT	EERS OF AMERICA			WA	SHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ζ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
W 249		n device had four voice ss:	W 2	49			
	- I would like to bru						
	- I would like to exe	ercise. :05 p.m., continued interview	i ned di Primi dendi internationale	in the second se			
W 331	with the QIDP reve	aled that the communication resented to the client during	w. 3	31	W 331  VOAC Administrative and Nursi will ensure that all recommend		
		rovide clients with nursing ance with their needs.			made by the Pharmacist are implemented and any report de	etailing	
	Based on observa review, the facility f from the pharmacis	is not met as evidenced by: tion, interview and record failed to ensure that reports st were addressed for one of the sample. (Client #1)			findings by the Pharmacist are a for review. VOAC will also ensu irregularities are addressed wit Primary Care Physician and the via documented discussion and	re that h the nurses	9
	The finding include		-		resolution in the nurses' notes.	VOAC	r
		2013 at 4:59 p.m., LPN #1 was			Quality Assurance team will me	ΛΛ.	-
		ister Metformin, Calcium, erry capsule to Client #1.	The state of the s		compliance per VOAC internal processes.	ŲA	
	a.m., revealed the regimen review for October 2, 2013. C	November 21, 2013, at 11:49 pharmacist conducted a drug Client #1 on April 4, 2013 and continued review of the record harmacist noted to "see report"			By 12/20/13		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PF7G11

Facility ID: 09G242

If continuation sheet Page 7 of 8

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

PRINTED: 12/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G242	B. WING			11/	22/2013
	PROVIDER OR SUPPLIER			431 53	ET ADDRESS, CITY, STATE, ZIP CODE BRD STREET, SE HINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	for irregularities and recommendations. failed to disclose a regimen irregularitie.  An interview with Li at approximately 2: the results of the plindicated that she widentified drug irregularities.  At the time of the sprovide evidence to	d/or pharmacist Further review of the record report describing the drug					
	_						
		S.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PF7G11

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Facility ID: 09G242

If continuation sheet Page 8 of 8

TATEMEN	egulation & Licensir T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		HFD03-0271	B. WING		11/	22/2013	
	PROVIDER OR SUPPLIER	431 53RD	DRESS, CITY, S' STREET, SE STON, DC 20				
(X4) ID PREFIX TAG	/FACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
1 000	November 20, 2013 A sample of three r population of five for intellectual disability The findings of the observations, intervalues of residents records and the Ghammar of the Group Home for Intellectual disabilities - GHIID Facility Coordinator Individual Support I Intermediate Care I Licensed Practical Medication Adminis Physician's Order -	was conducted from 3 through November 22, 2013. esidents was selected from a smales with varying degrees of ies.  survey were based on views with direct support staff, strative staff, as well as a medical and habilitation fillD's administrative records.  The abbreviations that may the body of this report.  DPS ressional - DSP dividuals with Intellectual in FC Plan - ISP reacility - ICF Nurse - LPN stration Record - MAR POS at Disabilities Professional -	1000				
I 180	3508.1 ADMINISTR Each GHMRP shall administrative supp needs of the reside Habilitation plans.		I 180				
-		met as evidenced by: on, interview and record				The same of the sa	

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If continuation sheet 1 of 8

Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 11/22/2013 HFD03-0271 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 431 53RD STREET, SE **VOLUNTEERS OF AMERICA** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1180 1 180 Continued From page 1 review, the QIDP failed to ensure each resident's communication device was integrate and coordinate with the day program, for one of the three sampled residents. (Resident #3) The finding includes: Cross-refer to Federal decifiency citation W249. The QIDP failed to ensure Resident #3's communication devices was implemented at the day program, as evidenced below: During resident observations on November 20, 2013. Resident #3 arrived home from day program at 3:50 p.m. The resident was escorted inside the GHIID in a custom-molded wheelchair. The surveyor verbally greeted the resident, but the resident did not respond. At approximately 3:55 p.m., DSP #2 informed the surveyor that Resident #3 was non-verbal. At 3:58 p.m., DSP #1 asked the resident how was her day at school. The resident did not respond. At approximately 4:00 p.m., DSP #1 provided Resident #3 with water as part of her snack. At 5:32 p.m., DSP #1 was observed talking to the resident during dinner; however, the resident did not respond. At 7:02 p.m., DSP #1 encouraged Resident #3 to press the keys on the keyboard. Again, the resident did not respond. Review of Resident #1's ISP records on October 28, 2013, at approximately 2:22 p.m., revealed an objective for <resident name> to visually discriminate/choose a leisure time activity using a four Icon voice device one time daily (Monday -Friday) in three of five consecutive trials. Interview with the QIDP on November 22, 2013. at approximately 1:00 p.m., revealed that Resident #3 was non-verbal and had a

Health Regulation & Licensing Administration STATE FORM

If continuation sheet 2 of 8

mighu, Stare Dieto 12/13/13

STATEMEN	degulation & Licensir IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	gota n	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		HFD03-0271	B. WING		11/22	/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VOLUME	EERS OF AMERICA	431 53RD	STREET, S	E		
VOLUNI	EERS OF AMERICA	WASHING	TON, DC 2	0019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
1 180	Continued From pa	ge 2	I 180			
inger en polyabel i selementemen (p) (n) (n) (n)	The QIDP stated th	rice that should be used daily. Lat the communication device d in the home and not at the Lam.		3509.6		
1 206	annually thereafter, certification that a h performed and that would allow him or duties.  This Statute is not Based on interview failed to ensure that care professionals	or to employment and shall provide a physician 's nealth inventory has been the employee 's health status her to perform the required  met as evidenced by: and record review, the GHIID tall employees and health had current health certificates DSPs (DSPs #3, and #4), 1 of	1206	VOAC will ensure that all consustaff are in compliance with the regulations and VOAC policy replications.  1. DSP #3 and #4 certificate are attached.  2. LPN #3 health Certificate is a VOAC will ensure through audit electronic data base for staff are consultant credentials that all reconsultant credentials that all reconsultant credentials.	garding ettached of its	
HITT TO THE PERSON OF THE PERS	7 LPNs (LPN #3). The findings include On November 21, 2 review of the perso			documents are kept current and available for review as needed.  By 12/13/13	8	
THE PARTY OF THE P	physician's health in #3 and #4. 2. There was no ev physician's health in	idence of a complete nventory/certificate for DSPs idence of a complete nventory/certificate for LPN #3.		<b>3520.3</b> See W 331		
113	On November 22, 2 p.m., the QDIP, wh	2013 at approximately 1:00 o had facilitated the review,		W 3521.3		
alth Regula	ation & Licensing Admini		8899	See W 159 and W 249		1 sheet

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	100	E CONSTRUCTION	(X3) DATE COMP	LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	Manager and American		
			48-7 DAMASOTOCISII			
		HFD03-0271	B. WING		11/2	2/2013
	TOOLUBER OF CHIRDUE	STREET AD	DRESS CITY.	STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER		STREET, S			
VOLUNT	EERS OF AMERICA		TON, DC 2			
140.000-75-95-90-9				PROVIDER'S PLAN OF CORRECTION	ON	(X5)
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	DBE	COMPLETE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
1110		2	-	DEFICIENCY)		
1206	Continued From pa	go 3	1206			
1 200		F0	1			
	acknowledged the	aforementioned findings. No				
		on was made available for				•
	review before the s	urvey ended.				
1 401	3520.3 PROFESSION	ON SERVICES: GENERAL	1401	•		
	PROVISIONS					
	248 AV1 80 4 700 T AVAILABLE TO	no seeds to the set of the				
		es shall include both diagnosis				
		uding identification of				
		is and needs, treatment	4			
		ces designed to prevent				
1		her loss of function by the				
	resident.					
	This Statute is not	met as evidenced by:		=		
		on, interview and record				
į		ailed to ensure that reports				
		t were addressed for one of				
-		in the sample. (Resident #1)				
	The finding includes	<b>5</b> :				
	0 11 1 00 0	545 14 50 LDN //4				
		013 at 4:59 p.m., LPN #1 was				
		ster Metformin, Calcium, rry capsule to Resident #1.			1	
	Keppia and Cianbe	Try capsule to Resident #1.			1	
	Record review on N	ovember 21, 2013, at 11:49			7	
1		harmacist conducted a drug				-
İ		Resident #1 on April 4, 2013			1	
	and October 2, 2013	3. Continued review of the				
		t the pharmacist noted to "see			1	1
1		ties and/or pharmacist				1
1		Further review of the record			1	
		eport describing the drug				
i	regimen irregularitie	S.			100	
-	Ån intender utt #	N 42 on November 24 2042				1
ĺ		N #2, on November 21, 2013,				1
		5 p.m., was held to ascertain armacist review. The LPN				. —
-	the results of the ph	annaoist review. The Little				

Health Regulation & Licensing Administration

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If continuation sheet 4 of 8

Connesser, State Devotor 12/13/13

STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD03-0271	B. WING	_	11/22/2013
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	11/22/2010
VOLUNT	EERS OF AMERICA	431 53RD	STREET, S	E	
- TOLOITI			TON, DC 2	promote and the second	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
I 401	identified drug irreginot able to locate th	ge 4 vas aware that the pharmacist ularities; however, she was e report and was unaware of	I 401		
	provide evidence to the pharmacist was care physician.	rvey, the nurse failed to ensure that the report from addressed by the primary	L		
1 422	and assistance to rethe resident's Indiv This Statute is not resident on observation review, the GHIID statile communication device were made a residents in the same The findings include  1. The GHIID failed	provide habilitation, training sidents in accordance with idual Habilitation Plan.  met as evidenced by: on, interview and record aff failed to ensure resident's on box and communication vallable, for two of three ple. (Residents #1 and #3)  to ensure Resident #1's on box was presented at	1 422		
THE CONTRACT	#1, who was visually observed being assi DSP #1 assisted the onto a spoon and placesident's hand. The to guide to spoon to				
1	On November 21, 20	013, beginning at 2:02 p.m.,		_	

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If continuation sheet 5 of 8

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nealui n	egulation & Licensin	g Administration			WAL DATE	CHDVEV
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
W-SURG-		HFD03-0271	B. WING		11/2	2/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
		431 53RD	STREET, SE			
VOLUNT	EERS OF AMERICA	WASHING	TON, DC 20	019		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
I <b>42</b> 2	review of Resident	#1's ISP dated February 25,	1422 .			
	to select (pick-up) hamong other object	resident had a formal program her drinking cup and spoon s in her tactile box prior to				
	dinner, one time a c Further review of th following steps:	day, Monday thru Friday. e program revealed the				
	- Staff will say <resi that will allow you to and drink with.</resi 	dent name>, we have a box choose what you need to eat	***			
	she may feel the re	hand in the empty box so that ctangle-shaped area and the as before placing items in				d
	- One at a time staf explore the box and	f will allow <resident name=""> to I its shape, etc.</resident>				
	that you eat with ins	, I am going to put your spoon side the box. Let's see if you . Staff will gently place the ne general area and allow her				
	out of the box, staff Staff will then say,	spoon and take the spoon will provide verbal praise. cresident name>, its dinner steps would be repeated for			· "=	
	approximately 4:10 #1 had a program to box prior to dinner f stated that staff was resident and encou box to find her cup	#4 on November 21, 2013, at pm., confirmed that Resident o use a tactile communication ive days a week. DSP #4 s to present the box to the rage her to reach inside the and spoon. DSP #4 further ram was not implemented on	q			

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199

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If continuation sheet 6 of 8



ealth Regulation & Licensing Administration  [ATEMENT OF DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA    ND PLAN OF CORRECTION   IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HFD03-0271	B. WING		11/22/2013
ANE OF FROVIDER OF CELL	DRESS, CITY, ST		
	STREET, SE STON, DC 200		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE   COMPLETE
November 20, 2013, prior to dinner. The QIDP was interviewed on November 22, 2013, at approximately 12:45 p.m., to ascertain information regarding Resident #1's tactile box. When asked to see the tactile box, the QIDP could not locate the box inside the GHIID.  2. The GHIID failed to ensure Resident 3's communication device was implemented at every opportunity, as evidenced below:  During resident observations on November 20, 2013, Resident #3 arrived home from day program at 3:50 p.m. The resident was escorted inside the GHIID in a custom-molded wheelchair. The surveyor verbally greeted the resident, but the resident did not respond. At approximately 3:55 p.m., DSP #2 informed the surveyor that Resident #3 was non-verbal. At 3:58 p.m., DSP #1 asked the resident how was her day at school. The resident did not respond. At approximately 4:00 p.m., DSP #1 provided Resident #3 with water as part of her snack. At 5:32 p.m., DSP #1 was observed talking to the resident during dinner; however, the resident did not respond. At 7:02 p.m., DSP #1 encouraged Resident #3 to press the keys on the keyboard. Again, the resident did not respond.  Review of Resident #1's ISP records on October 28, 2013, at approximately 2:22 p.m., revealed an objective for <reident name=""> to visually discriminate/choose a leisure time activity-using a four lcon voice device one time daily (Monday-Friday) in three of five consecutive trials.</reident>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HFD03-0271		B. WING		11/2	11/22/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
VOLUNTEERS OF AMERICA 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
I 422	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1422			
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If continuation sheet 8 of 8