PRINTED: 12/27/2013 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICATION			JUTIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		09G239	B. WING		12	/04/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20019		1 12/04/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE	
W 000	INITIAL COMMENT	rs .	woo	00			
	November 18, 2013 A sample of three of population of two may varying degrees of in survey was initiated process. During the comprehensive review #5's health care and conducted.  The findings of the subservations, interview of clients' mediand the facility's administration.	abbreviations that may					
F F D G D in In Li M Pi Q Q R	Disabilities - GHIID Individual Support Pla Intermediate Care Fac Icensed Practical Nu Iedication Administra Intermediate Order - PC Iualified Intellectual D IdP Intermediate Nurse - RN Intermediate RN	e - HWR an - PCP sional - DSP iduals with Intellectual in - ISP cility - ICF rse - LPN tion Record - MAR OS	W 189				
Th	he facility must provid	de each employee with					

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that to other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 program participation.

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

Event ID: DV2Y11

Facility ID: 09G239

If continuation sheet Page 1 of 13

O COLUMN	THO ! OIL MILDIONIL	A MICHICAID SERVICES			OMR NO	. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		09G239	B. WING_		12/	04/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
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iii aa ba sa da CC 2 fa A	initial and continuing employee to perform efficiently, and compare the efficiently far effectively trained to outlined in each clier for one of the three of the efficient efficien	ntraining that enables the mills or her duties effectively, betently.  In the tas evidenced by:	W 189	W189  VOAC will ensure that training staff is effective. QIDP/RC, not consultants will conduct training use staff regularly to ensure information shared during the understood and staff can trainformation to the daily function to the daily function to the understood and assessment Particular attention will be gistered to concerns about the weight.	urses and ning and the raining is nsfer the ctions. of all staff	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G239	B. WING			12/04/2013	
75 5000000000000	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 4515 EDSON PLACE, NE WASHINGTON, DC 20019	CODE		
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W 18	18, 2013, confirmed a low fat, low salt 12 how many chicken responded by saying also stated that she chicken nuggets in the on top of the store On November 19, 20 the Client #3's vital s 2013 through July 20 weight increases:  November 2013 weight - October 2013 weight - August 2013 weight - July 2013 weight was Further review of the the client's HVVR was Client #3 remains with continues to increase Review of the In-servinovember 20, 2013, all staff had received nutritional needs on N	I that Client #3 was prescribed 200 calorie diet. When asked 200 calorie diet. When asked 200 calorie diet. When asked 200 calorie diet, DSP #3 201 200 calorie diet, DSP #3 201 201 201 201 201 201 201 201 201 201	W 18				
W 242	implemented or effect		W 242				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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orannas occus	PROVIDER OR SUPPLIER FEERS OF AMERICA			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD <b>B</b> E	COMPLETION DATE	
t set to the set of th	those clients who late skills essential for proceedings, but not lire personal hygiene, of bathing, dressing, groof basic needs), until that the client is deviac acquiring them.  This STANDARD is Based on observation review, the facility fail with training to reduct of a bib during mealth clients included in the The finding includes: The facility failed to phenomenate of a bib.  Client #3 was observed use of a bib.  Client #3 was observed on through 5:22 p.m. food spillage observed in the client wiped her moves given verbal praise when asked, the QIDF around Client #3's need apper towel. Again, the pillage observed. At DSP #2 was interviewed.	ge 3 am plan must include, for ock them, training in personal rivacy and independence mited to, toilet training, ental hygiene, self-feeding, rooming, and communication it has been demonstrated elopmentally incapable of the dependency on the use of the dependency of the dependency of the dependency of the dependency on the dependency of t	W 242	W242  VOAC will ensure to the extent and based on the individuals IS functional abilities that staff ar on how to support each individual their. QIDP will ensure that to extent possible, the individual in question gets an opportunity to participate fully in her activities living to include mealtime.  By 1/4/14	P and e trained lual using the n		

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S	1PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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F P P P P P P P P P P P P P P P P P P P	stated that Client #3 mealtime to protect queried if a cloth bib restaurants, DSP #2 Client #3 used the restaurants, DSP #2 Client #3 used the restaurants part of the restaurants of the restaurant place to teach the client during mealtimes, the 483.460(c) NURSING The facility must provide services in accordance. This STANDARD is a Based on interview a failed to ensure that in the PCP of the frequest and itching, for one of sample. (Client #2) The finding includes: The facility nursing staurants of the redications for Client Review of the medical and redications for Client Review of the medical 2013, at 11:10 a.m., restaurants.	wore a cloth bib during her clothing. When further was worn while on outings at responded by saying, "no", estaurant cloth napkin.  DP on November 19, 2013, d that Client #3 was more g a paper towel and/or cloth mes to protect her clothing. was a training program in ent to protect her clothing e QIDP replied "No".  SERVICES ride clients with nursing ce with their needs.  Into the as evidenced by: and record review, the facility pursing personnel informed and use of the PRN ered for nausea/vomiting in the three clients in the end of the frequent use of PRN #2, as evidenced below:  records on December 3, evealed Client #2 had a ltchy scalp, Pruritus, dermatitis,	W 331		use of ensure to the	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G239	B. WING	10 <sup>-1</sup> - 20-10 <sup>-1</sup>	12	2/04/2013
V-m-v-m-	PROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 515 EDSON PLACE, NE VASHINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
	Inversus. Review of physician's orders (I prescribed Benadryl Pruritus and Phener (insert 1 suppository as needed for nause On December 3, 20 the October 2013 and corresponding nursing staff administ of Benadryl for Prurit nausea, vomiting and indicated below:  October 7, 2013 - Ewere administered all corresponding nursing medications were effire respectively.  October 8, 2013 - Benergan (8:00 p.m. MAR documented that helpful.  October 9, 2013 - Bewere administered at documented that the land helpful, respectively.  October 10, 2013 - Bewere administered at documented that the land helpful, respectively.	sophagitis, and Situs the September 2013 POs) revealed Client #2 was 25 mg PRN at bedtime for gan 25 mg suppository rectal rectally every twelve hours a and vomiting).  13, at 11:12 a.m., review of ad November 2013 MARs and ng notes revealed that the stered the PRN medications tus and Phenergan for d itching 17 out of 34 days as  Benadryl and Phenergan t 8:00 p.m. The MAR and ng note documented that the ective and helpful,  senadryl (6:00 p.m.) and h) were administered. The at the medications were  enadryl and Phenergan 8:00 p.m. The MAR medications were effective ely.  Benadryl and Phenergan 8:00 p.m. The MAR medications were effective	W 331			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
. ser	were administered a documented that the . October 14, 2013 - Phenergan (8:00 p.r MAR documented ti effective.  October 17, 2013 - The MAR did not ref medication was effection with the medication with the medication with the medication was effect october 19, 2013 - were administered. The MAR did not reflemedication was effect october 25, 2013 - I administered. The MAR did not reflemedication was effect october 28, 2013 - I administered. The MAR did not the medication was october 28, 2013 - I administered. The MAR did not the medication was october 1, 2013 - I administered. The MAR did not the medication was october 1, 2013 - I administered. The MAR did not the medication was effect November 4, 2013 - I were administered at 8 october 4, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 24, 2013 - I were administered at 8 october 25, 2013 - I were administered at 8 october 25, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 26, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administered at 8 october 27, 2013 - I were administere	at 8:00 p.m. The MAR e medications were effective.  Benadryl (6:00 p.m.) and m.) were administered. The nat the medications were  Benadryl was administered. lect whether or not the ctive.  Phenergan was AR did not reflect whether or ras effective.  Benadryl and Phenergan The MAR did not reflect edications were effective.  Benadryl was administered. act whether or not the tive.  Phenergan was AR did not reflect whether or as effective.  Phenergan was AR did not reflect whether or as effective.  Phenergan was AR did not reflect whether or as effective.  Benadryl was administered R documented the live.  Benadryl and Phenergan	W 331			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G239	B. WING		12	/04/2013	
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	were administered a documented that the November 6, 2013 were administered a documented that the November 7, 2013 were administered a documented that the November 7, 2013 were administered a documented that the Interview with the LF 4:10 p.m., revealed with Client #2 for owniterview with the LF was aphasic (non-veeplsodes of itching (and hands) several the discussion with the LE exhibited frequent vo October 2013 and November 2013, at 10:05 a.m., utilized a form to doc of vomiting. The form Monitoring Form" (Visited three times in November 2013 and November 2013 a	at 8:00 p.m. The MAR e medications were helpful.  - Benadryl and Phenergan at 8:00 p.m. The MAR e medications were effective.  - Benadryl and Phenergan at 8:00 p.m. The MAR e medications were effective.  - Benadryl and Phenergan at 8:00 p.m. The MAR e medications were effective.  - PN on December 4, 2013 at that he had been working er two years. Further er two years. Further are two years. Further er two years. Further er two years. Further er two years. Further are two years. Further er two years. Fu	W 331				

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	(X3) DATE SURVEY COMPLETED		
		09G239	B. WING		12/04/	12043
	PROVIDER OR SUPPLIER	L 2000		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019	12/04/	2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE C	(X5) OMPLETION DATE
W 368	on the MAR, he did VMF.  Interview with the R 3:03 p.m., revealed about notifying him medications (Phene administered. The I the PCP, the nursing each time PRN medications outside to see notifications to use of the PRN medications outside to see notifications to use of the PRN medications outside to see notifications to use of the PRN medications outside to see notifications to use of the PRN medications outside to see notifications to use of the PRN medications of the PRN medication of the physician order.  The system for drug that all drugs are adrithe physician's order.  This STANDARD is Based on observation of the physician's order. (Client #1)  The finding includes:  On November 18, 20  LPN #2 was observed schial decubitus with	N, on December 3, 2013, at that she spoke to the PCP each time Client #2's PRN rgan and Benadryl) were RN stated that according to g staff did not have to call lications were administered not administering the of the orders. When asked the PCP for the frequent lications for October 2013 to the RN stated that she did none calls in the nursing ADMINISTRATION administration must assure ministered in compliance with	W 368	W368  VOAC and the nursing team will that individuals receive their medication regiment as prescrib documented in the Physician Ord Sheet. Sure prep has since been purchased and is in use accordin POS. VOAC and RN will ensure the nurses are in-serviced on following the service of the servic	ed and der g to the nat the	

	THO TOT WEDTONING	A MEDIO NO CENTRICE	-		MID MO. DOOD-DOO
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
		09G239	B. WING		12/04/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VOLUNT	TEERS OF AMERICA			4515 EDSON PLACE, NE	
	- AUROLONIA			WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 368		ge 9 Dakins Solution and secured	W 368		
1	On November 19, 20 the client's physiciar November 15, 2013. Sure Prep to the sur ischial decubitus.  Interview with LPN # 11:15 a.m., revealed protect the skin and	, the LPN failed to apply Sure	W 440		
	quarterly for each shi This STANDARD is a Based on Interview a failed to hold evacuat the five shift of duty re	evacuation drills at least ift of personnel.  not met as evidenced by: and record review, the facility ion drills quarterly, for one of eviewed (weekend 6:00 p.m.		W 440	
i e	east four times (4) a yevidenced below: On November 18, 201 vith DSP #1 revealed lesignated shifts (8:00	0 a.m 4:00 p.m.; 4:00 12:00 a.m 8:00 a.m.),		VOAC will ensure that fire drills at conducted according to the regular requirements; one per shift per quivoAC will ensure that RC and QID monitor the data collection proceensure drills are documented accordingly.  By 1/10/14	atory uarter. P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G239	B. WING_		12/	12/04/2013	
	NAME OF PROVIDER OR SUPPLIER  VOLUNTEERS OF AMERICA			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019			
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W 440	revealed that there (6:00 a.m 6:00 p.r for the weekend (Sa	were two designated shifts n. and 6:00 p.m 6:00 a.m.)	W 44	0			
W 448	revealed that no dril weekday shift (12:00 January 2013 throug shift (6:00 a.m 6:0 a.m.) from January 2 At 2:59 p.m., the QII reports and confirme conducted during the	s were held during the community and the communi	W 448	3			
	The facility must inve evacuation drills, incl	stigate all problems with uding accidents.			d		
	Based on observation review, the facility fail problems with evacuand addressed, for find facility. (Clients #1, #The finding includes: On November 18, 20 from 9:05 a.m. throug Clients #1, #2, #3 and utilized a custom-mol	not met as evidenced by: n, interview and record led to provide evidence that ation drills were investigated /e of the five clients in the 2, #3, #4 and #5)  13, observations conducted in 7:20 p.m., revealed i #5 were non-mobile and ded wheelchair for their zed a standard wheelchair		VOAC will ensure that QIDP, Re and Quality Assurance Coordin review and where necessary in problems with drills. The time for conducting drills will be exa ensure all staff conducting drill understands what the acceptal frame for a drill is.  By 1/10/14	ator vestigate frame mined to	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G239	B. WING		1	2/04/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019			
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	for mobility. All five have hospital beds Review of the fire experiod January 2013 was conducted on Nat 2:15 p.m. The far drills conducted duriperiod. While some more-than 10 minutes complete during the below:  - an overnight drill of took one and half minutes a complete;  - an overnight weeke reportedly took three minutes a complete;  - an overnight drill on reportedly took three to complete;  The QIDP and DSP is November 18, 2013, mentioned that sever three minutes to comfire drills, they (QIDP responded by saying, the clients overall heast attend that there was during the overnight are quired a two-person further queried to assort the person further queried to assor	clients were also observed to in their bedrooms.  vacuation drills from the 3 through November 2013 lovember 18, 2013, beginning clity had documented several ing the twelve (12) month of the drills were drills achieved tes, several took less time to overnight shift, as evidence in May 17, 2013, reportedly inutes to complete; in August 31, 2013, reportedly ind fifteen seconds to an August 31, 2013, minutes to complete; and, in October 30, 2013, minutes and fifteen seconds  41 were both interviewed on at 2:59 p.m. When all fire drills took less than uplete the aforementioned	W 44	8			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  OGG239  NAME OF PROVIDER OR SUPPLIER  VOLUNTEERS OF AMERICA  NAME OF PROVIDER OR SUPPLIER  VOLUNTEERS OF AMERICA  STREET ADDRESS, CITY, STATE, ZIP CODE  44516 BOSON PLACE, NE  WASHINGTON, DC 20019  PRIEFIX  REGULATORY OR LISC IDENTIFYING INFORMATION)  W 448  Continued From page 12  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.	CEIVIE	MO FOR MIEDICANE	& MEDICAID SERVICES			UI	AR MC	<i>).</i> บย38-03	y1
NAME OF PROVIDER OR SUPPLIER  VOLUNTEERS OF AMERICA  STREET ADDRESS, CITY, STATE, ZIP CODE  4515 EDSON PLACE, NE  WASHINGTON, DC 20019  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 448  Continued From page 12 provide information and/or documented evidence that the issue had been addressed.  At the time of the survey, the facility falled to provide evidence that problems associated with							(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  VOLUNTEERS OF AMERICA  STREET ADDRESS, CITY, STATE, ZIP CODE  4515 EDSON PLACE, NE  WASHINGTON, DC 20019  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  WASHINGTON, DC 20019  ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE)  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  W 448  Continued From page 12			09G239	B. WING			12	/04/2013	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 448  Continued From page 12 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					4515 EDSON PLACE, NE	ODE			
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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD	BE	COMPLETIO DATE	N
	W 448	provide information that the issue had b At the time of the su provide evidence that	and/or documented evidence een addressed. ervey, the facility failed to at problems associated with	W 4	48				

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 09G239 12/04/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE VOLUNTEERS OF AMERICA WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX DATE TAG DEFICIENCY) 1000 **INITIAL COMMENTS** 1000 A licensure survey was conducted from November 18, 2013 through December 4, 2013. A sample of three residents was selected from a population of two males and three females with varying degrees of intellectual disabilities. During the course of the survey, a comprehensive review of Resident #2's and Resident #5's health care and nutritional status was conducted. The findings of the survey were based on observations, interviews, and the review of records, including incident reports. Note: The below are abbreviations that may appear throughout the body of this report. Primary Care Physician - PCP Pounds - lbs 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 3505.5 Physician's Order - POS Qualified Intellectual Disabilities Professional -VOAC will ensure that fire drills are OIDP conducted according to the regulatory Registered Nurse - RN requirements; one per shift per quarter. VOAC will ensure that RC and QIDP 1 135 3505.5 FIRE SAFETY 1135 monitor the data collection process to Each GHMRP shall conduct simulated fire drills in ensure drills are documented order to test the effectiveness of the plan at least four (4) times a year for each shift. accordingly. By 1/10/14 This Statute is not met as evidenced by: Health Regulation & Licenting Administration
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DV2Y11 COOL CHIVOID

TITLE

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING. 09G239 12/04/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE **VOLUNTEERS OF AMERICA** WASHINGTON, DC 20019 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY) 1135 Continued From page 1 1135 Based on interview and record review, the GHIID failed to hold evacuation drills quarterly, for three of the five shift of duties reviewed (Weekday 12:00 a.m. - 8:00 a.m. and weekend 6:00 a.m. -6:00 p.m. and 6:00 p.m. - 6:00 a.m.), The finding includes: The GHIID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On November 18, 2013, at 2:12 p.m., interview with DSP #1 revealed that there were five designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.). Monday through Friday. Further interview revealed that there were two designated shifts (6:00 a.m. - 6:00 p.m. and 6:00 p.m. - 6:00 a.m.) for the weekend (Saturday/Sunday). Review of the GHIID's fire drill records on November 18, 2013, beginning at 2:15 p.m. revealed that no drills were held during the weekday shift (12:00 a.m. - 8:00 a.m.) from January 2013 through March 2013 and weekend shift (6:00 a.m. - 6:00 p.m. and 6:00 p.m. - 6:00 a.m.) from January 2013 through March 2013. At 2:59 p.m., the QIDP reviewed the fire drill reports and confirmed that no drills were conducted during the aforementioned time periods (January 2013 - March 2013). The QIDP then stated that she would follow-up with management staff regarding this issue. 1401 3520.3 PROFESSION SERVICES: GENERAL 1401 **PROVISIONS** Health Regulation & Licensing Administration

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	and evaluation, includevelopmental level services, and serviced deterioration or furth resident.  This Statute is not in Based on interview a failed to ensure that the PCP of the frequimedications administ and itching, for one cannot be sample. (Resident # The findings include:  The GHIID nursing sinclude:  The GHIID nursing sinclude	es shall include both diagnosis ading identification of and needs, treatment es designed to prevent er loss of function by the er loss of function by the enet as evidenced by: and record review, the GHIID nursing personnel informed ent use of the PRN tered for nausea/vomiting of the three residents in the er of the frequent use of PRN dent #2, as evidenced below: at records on December 3, evealed Resident #2 had ed itchy scalp, Pruritus, ands, hiatal hemia, apphagitis, and Situs he September 2013 Ds) revealed Resident #2 dryl 25 mg PRN at bedtime ergan 25 mg suppository sitory rectally every twelve ausea and vomiting).  It at 11:12 a.m., review of November 2013 MARs and notes revealed that the ered the PRN medications and Phenergan for	1401	3520.3  See W 331 and W 368  VOAC will ensure that its nursin personnel inform the PCP of the frequent use of PRN medication Nurses will notify PCP once PRN medication becomes frequent to that The PCP is aware and agree use of the PRN frequently. The R be counseled on the need to docher phone calls to the PCP.  By 1/14/14	s. use of ensure to the
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**		sing staff failed to apply sure	Ī		1		
	prep to Resident #1	as prescribed by the PCP.					
	On November 40 O	042 hadinding at 8:00 a m		VOAC and the nursing team wil	Lenguro	J.	
	I PN #2 was observe	013, beginning at 6:30 p.m., ed cleaning Resident #1's left		that individuals receive their	CHISCIE		
	ischial decubitus with	h "Skintegrity" wound cleaner.					
	LPN #2 then moister	ned a Kerlix guaze in a	1	medication regiment as prescril	oed and		
		Dakins Solution and secured		documented in the Physician Or		- 1	
	it to the wound.		1	Sheet. Sure prep has since been			
	On November 19, 20	013, at 9:30 a.m., review of	l	purchased and is in use according	ng to the		
	the resident's physic	ian's order sheets (POS)		POS. VOAC and RN will ensure t	hat the		
	dated November 15,	2013, revealed an order to		nurses are in-serviced on follow			
	apply Sure Prep to the left ischial decubitus.	ne surrounding tissue of the	l	and an activitied of follow	ing POS.		
	leit ischiai decubilus.					- 1	
	Interview with LPN #	1 on November 19, 2013, at					
	11:15 a.m., revealed	Sure Prep should be used to		By 1/17/14		1	
	protect the skin and I	keep the tape on.	H				
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1422	3521.3 HABILITATIO	N AND TRAINING	1422	1			
	Each GHMRP shall p	rovide habilitation, training				ľ	
	and assistance to res	idents in accordance with					
	the resident 's Individ	fual Habilitation Plan.		88	1	Ī	
	This Statute is not m	at an avidanced but				ı	
	Based on observation	i, interview and record					
	review, the GHIID faile	ed to provide each resident		£			
	with training to reduce	the dependency on the use					
	of a bib during mealting	nes, for one the three			l		
	realderna michigad iv I	the sample. (Resident #3)					
	The finding includes:				-		
1	The OLUMB Collection	and the second s				1	
	The GHIID failed to pr	ovide evidence that				l	

Health	Regulation & Licensii	ig Administration					
	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		İ					
		800800	B. WING				
		09G239	O. WING_		12/0	04/2013	
NAME O	F PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY	, STATE, ZIP CODE			
			ON PLACE				
VOLUN	ITEERS OF AMERICA		STON, DC	-			
W41.15	DIMMADY OTA	TEMENT OF DEFICIENCIES					
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR LE	BC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE	
				DEFICIENCY)		1 1	
1 422	Continued From page	ne 7	1422				
	Toom pa	3	1422				
	Resident #3 was giv	en an opportunity to learn				! <b>!</b>	
		lothing during mealtimes	1				
	without the use of a	bib.					
		contraction and a major unique			1	l 1	
	Resident #3 was ob	served wearing a cloth bib				1	
	auring ainner time o	n November18, 2013, from			-		
	5:05 p.m. through 5:	22 p.m. There was minimal		1			
	A+ E-19 pm DCD #	bserved throughout the meal. 2 was observed to hand					
	Resident #3 a napkii	2 was observed to hand		İ			
	Momente later the r	esident wiped her mouth			1		
	independently and us	as given verbal praise by					
	staff. At 5:22 n m. w	hen asked, the QIDP				1	
	removed the bib from	n around Resident #3's neck					
	and replaced it with a	a paper towel. Again, there					
	was minimal to no fo	od spillage observed. At			1	1	
	approximately 5:25 p	.m., DSP #2 was interviewed			1	i i	
	to ascertain why Res	ident #3 wore a cloth bib			1	1	
	during dinner time. D	SP #2 stated that Resident				1	
1	#3 wore a cloth bib d	uring mealtime to protect her				1	
	clothing. When furth	er queried if a cloth bib was				l	
	worn while on outings	at restaurants, DSP #2				I	
	responded by saying,	"no", Resident #3 used the			1		
-	restaurant cloth napk	in.			1		
1	International Manager	NO. N				f	
1	of 2:30 a murriage	OP on November 19, 2013,					
	than capable of union	that Resident #3 was more a paper towel and/or cloth			1	- 1	
1	nankin during meeting	nes to protect her clothing.	1			1	
	When asked if there	vas a training program in					
1	place to teach the ree	ident to protect her clothing	l			1	
	during mealtimes, the	OIDP replied "No"				1	
		The second state of the second					
		<b>.</b>				ŀ	
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1			Ì			- 1	
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Health Regulation & Licensing Administration STATE FORM