

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD12-0002             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>07/09/2010 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>NATIONAL CHILDREN'S CENTER |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6809 9TH ST, NW<br>WASHINGTON, DC 20012 |   |  |
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| 1 000  | INITIAL COMMENTS<br><br>A re-licensure survey was conducted on July 9, 2010. A random sample of two residents was selected from a resident population of five males with varying degrees of cognitive and intellectual disabilities. The findings of the survey were based on observations, interviews with direct support staff, residents and administrative staff in the home, as well as a review of resident and administrative records, including incident reports.   | 1 000  |   |  |
| 1 082  | 3503.10 BEDROOMS AND BATHROOMS<br><br>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to equip all bathrooms used by residents with paper towels, for two of the five residents of the facility. (Residents #1 and #4)<br><br>The finding includes:<br><br>On July 9, 2010, at 7:00 p.m., observation revealed that there were no paper towels in the bathroom located in the bedroom shared by Residents #1 and #4. The program coordinator acknowledged that there were no paper towels then indicated that staff would place a new roll in that bathroom. | 1 082  |   |  |
| 1 090  | 3504.1 HOUSEKEEPING<br><br>The interior and exterior of each GHMRP shall be   | 1 090  | Paper Towels were purchased for the home.   | 7/12/2010                                    |

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION ADMINISTRATION  
825 NORTH CAPITOL ST., N.E., 2ND FLOOR  
WASHINGTON, D.C. 20002

OCT - 5 2010

Health Regulation Administration

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

STATE FORM

TITLE

(X5) DATE

*Director of Residential Services* 8/23/2010

6888

BZDM11

If continuation sheet 1 of 8

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| 1090               | <p>Continued From page 1</p> <p>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:<br/>Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for five of the five residents in the facility. (Residents #1, #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>Observation and interview with the facility's program coordinator (PC) on July 9, 2010, beginning at 6:30 p.m. revealed the following:</p> <p>Exterior:</p> <ol style="list-style-type: none"> <li>1. There was an accumulation of lint in the duct leading from the clothes dryer to the outside vent; therefore, presenting a potential fire.</li> <li>2. The picnic table in the back yard was made of wood. The wood was old, warped and splintered in numerous places, therefore, presenting a potential safety hazard. The condition of the wood was unattractive.</li> <li>3. Paint on the exterior of the door leading from the bedroom shared by Residents #1 and #4 to the back yard was scratched/ damaged in an area approximately 2 ft x 2 ft, towards the bottom.</li> </ol> <p>Interior:</p> | 1090          | <ol style="list-style-type: none"> <li>1. The Maintenance Department will purchase additional equipment to attach to the Aspen home vacuum. The additional attachments will be used by Aspen staff to clean the lint in the duct leading from the clothes dryer to the outside vent once a <u>month</u>.</li> <li>2. The Maintenance department will dispose of our picnic table in the back yard to reduce potential safety hazarded.</li> <li>3. The Maintenance department will have the Resident #1 and #4 bedrooms leading to the back yard painted.</li> </ol> | <p>9/9/2010</p> <p>9/9/2010</p> <p>9/9/2010</p> |

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| I 090  | Continued From page 2<br><br>4. Paint on the closet doors in the bedroom shared by Residents #1 and #4 and on the walls in the dining room/living room area was scratched/damaged.<br><br>5. Carpeting throughout the facility was severely soiled and/or stained. The PC indicated that a request for carpet cleaning had been submitted during the previous week; however, no date for the cleaning had been announced.<br><br>The PC acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.  | I 090  | 4. The Maintenance department will paint closet door in resident's #1 and #4 bedroom and on the wall in the dining room/living room area.<br><br>5. The carpet in the Aspen Home will be replaced in soiled and/or stained areas. | 9/9/2010<br><br>9/9/2010                     |
| I 165  | 3507.4(c) POLICIES AND PROCEDURES<br><br>The manual shall incorporate policies and procedures for at least the following:<br><br>(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident;<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure a policy on securing newly-prescribed medications timely.<br><br>The finding includes:<br><br>On July 9, 2010, at approximately 1:30 p.m., review of Resident #2's physician's orders (POs) revealed that on February 24, 2010, the client was prescribed Doxycycline Hyclate 100 mg by mouth, twice daily for 2 weeks after having visited the dermatologist. At 3:40 p.m., review of Resident #2's Medication Administration Records | I 165  |   |  |

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| 1165   | Continued From page 3<br><br>(MARs) for February 2010 and March 2010 revealed that the first administration of the prescribed Doxycycline was documented on March 4, 2010 at 8:00 p.m. (8 days after the order was written). At 3:51 p.m., the program coordinator (PC) looked at the MARs and acknowledged that 8 days had passed before the resident began receiving the antibiotic, for reasons not known. The PC immediately began searching through the policies and procedures manual. At 6:27 p.m., he presented a policy titled "Medication: Pharmacy Revised 11/03," however, he stated that it did not address the subject re: expected time frame for securing prescription medications. Moments later, review of said policy confirmed that it did not provide the GHMRP any guidance regarding timely adherence to physician's orders. | 1165   | The GHMRP will ensure The Registered Nurse, License Practical nurse will be trained on the Medication Ordering and Transcription Policy to avoid any potential delays (see attachment #1). | 9/9/2010                                     |
| 1372   | 3519.3 EMERGENCIES<br><br>Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.<br><br>The finding includes:<br><br>On July 9, 2010, at 7:16 p.m., interview with the program coordinator and the house manager   | 1372   |  |  |

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| 1372   | Continued From page 4<br><br>revealed that there was one telephone in the facility. It was located in the dining room. Moments later, observation revealed that there was no list of emergency contact numbers posted near the telephone. At 8:15 p.m., the program coordinator presented an "Emergency Contacts" list, which he posted by the telephone. The deficiency, therefore, was abated during the survey.   | 1372   | The emergency contact list was presented at 8:15pm by PC.   |  |
| 1500   | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District laws that govern the care and rights of persons with mental retardation, for two of the two residents in the sample. (Residents #1 and #2)<br><br>The findings include:<br><br>Chapter 13, § 7-1305.05. Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly § 6-1965]<br><br>(g) Each customer shall have the right to prompt and adequate medical attention for any physical ailments... | 1500   |   |  |

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| I 500              | <p>Continued From page 5</p> <p>1. The GHMRP failed to ensure timely immunizations for Resident #1, as follows:</p> <p>On July 9, 2010, at approximately 11:20 a.m., review of Resident #1's immunizations chart revealed that he had received a Diphtheria Tetanus (DPT) shot on August 24, 1999. The chart indicated that he was to receive another booster shot in August 2009. Subsequent review of the resident's Nurse Progress Notes (from March 2009 onward), Monthly Physician's Assessment forms (from April 2009 onward) and other documents in his medical chart failed to show evidence that the resident had received the booster shot as recommended.</p> <p>At 3:01 p.m., the program coordinator (PC) stated that DPT booster shots should be scheduled "every 10 years" and upon review of the resident's immunization chart, he confirmed that a booster had been due in August 2009. He then indicated that he would seek information from the nursing team. No additional information was presented before the survey ended at 7:40 p.m. that evening.</p> <p>2. The GHMRP failed to ensure that Resident #2's primary care physician received the findings and recommendations of diagnostic procedures (i.e. serum lab tests) timely, as follows:</p> <p>On July 9, 2010, at approximately 1:30 p.m., review of Resident #2's physician's orders revealed that on February 24, 2010, his primary care physician (PCP) ordered "abdomen ultrasound to rule out gallstones." A PCP Progress Note dated February 24, 2010 included "abdomen ultrasound to rule out gallstones. Hyperbilirubin can lead to pruritis..." [Note:</p> | I 500         | <p>Resident #1 will be administered his Tetanus (DPT) shot before September 15, 2010 by Primary Care Physician. The GHMRP will ensure all residents in the home receive the necessary immunizations in a timely manner.</p> | 9/15/2010          |

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| 1500   | <p>Continued From page 6</p> <p>Pruritis is defined as itchy skin.] Resident #2's lab reports indicated that on February 7, 2009, his serum bilirubin measured 1.24 mg/dl (higher than reference range 0.0 - 1.0 mg/dl). On January 30, 2010, his bilirubin measured 2.40 mg/dl, almost twice the levels tested a year earlier. At 2:05 p.m., review of a PCP progress note dated June 27, 2010, revealed the following: "March 18, 2010 ultrasound to rule out gallstones. No results posted."</p> <p>At approximately 3:30 p.m., the PC presented a radiology report dated March 18, 2010, that showed the results of the ultrasound. No gallstones were evidenced. There were no PCP initials on the lab report and review of the resident's medical chart failed to show evidence that the findings had been conveyed to the PCP. The PC acknowledged that the resident's record did not reflect whether the PCP was aware of the March 18, 2010 lab findings. He further indicated that the house nurse and the supervisory RN were both on leave and unavailable on the survey date.</p> <p>There was no evidence that PCP received results of serum lab tests timely, to ensure evaluation of elevated serum bilirubin levels.</p> <p>It should be noted that Resident #2's behavior support plan (BSP), dated April 19, 2010, reflected a target behavior of "skin picking... picking and aggressively rubbing his fingers, face, ears, back of neck and forehead." His behavior data collection sheets indicated ongoing skin picking behavior. In addition, a Nurse Progress Note dated March 3, 2010, reflected "Dermatology appointment for long term management of skin eruptions ordered. Doxycycline... and topical... ordered."</p> | 1500   | The GHMRP will ensure nurse will obtain and presented Primary Care Physician with results from all specialty appointments in a timely manner. In addition the Nurse will be trained on Physician Oversight Policy (See Attachment #2). | 9/9/2010                                     |

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