

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2010
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 302 'S' ST, NE WASHINGTON, DC 20002
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I 000	<p>INITIAL COMMENTS</p> <p>Surveyor: DC007</p> <p>A licensure survey was conducted on August 23, 2010 thru August 24, 2010. A sampling of three residents from the residential population of five males was selected for the survey. The results of the survey was based on observations in the home, interviews with the administrative, nursing and direct care staff, as well as a review of the resident and administrative records and incident reports.</p>	I 000	<p style="font-size: 2em; transform: rotate(-15deg); opacity: 0.5;">Received 9/15/10 DOH-MRLH-ICFO</p>	
I 090	<p>3504.1 HOUSEKEEPING</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: Surveyor: DC007 Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5)</p> <p>The findings include:</p> <p>On August 24, 2009, beginning at 11:28 a.m., a walk through of the GHMRP with the house manager (HM) revealed the following:</p> <p>Interior</p>	I 090		

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Michael Wan

TITLE *Program Director*

(X6) DATE *9/15/10*

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

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I 090	Continued From page 2 needed to be addressed.	I 090		
I 134	3505.4(e) FIRE SAFETY Each GHMRP shall have on the premises the following items: (e) Fire extinguishers, which are properly maintained and located as required by the Fire Chief, including at least one (1) all-purpose fire extinguisher, which is a minimum 2A 10BC on each level of the facility. This Statute is not met as evidenced by: Surveyor: DC007 Based on observation and interview, the facility failed to properly maintain one (1) of the four (4) fire extinguishers in the facility. The finding includes: On August 24, 2010 an inspection of the GHMRP's fire extinguishers was completed. Observation of the extinguisher tags revealed the last serviced date for the fire extinguisher in the basement was in May 2009. The House Manager (HM) verified that this was an over-site and the extinguisher would be serviced or replaced by August 25, 2010.	I 134	Fire extinguishers were replaced and <i>our</i> Facility Checklist form (see attached) was revised to include fire extinguishers on pg 2 of checklist.	9/15/10
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.	I 135		

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I 135	Continued From page 3 This Statute is not met as evidenced by: Surveyor: DC007 Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 8/24/10, at 1:59 p.m., revealed the scheduled shifts are as follows: Weekdays/Weekends 1st Shift 8:30 AM to 4:30 PM 2nd Shift 3:00 PM to 10:30 PM 3rd Shift 10:30 PM to 8:30 AM Further interview with the House Manager revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log for August 2009 through July 2010 revealed that the facility failed to hold fire evacuation drills for the 3rd Shift (10:30 PM to 8:30 AM). The House Manager acknowledged that the fire drills during this time was not documented in the record at the time of the survey.	I 135	<i>Upon review of the fire drill log there were fire drills done on the 10:30pm to 8:30 am shift (see attached). However we will instruct staff that drill <u>must</u> be done during all hours of the shift and not just after 7 am.</i>	<i>9/15/10</i>
I 164	3507.4(b) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (b) Physical environment, which covers housekeeping, maintenance, household items and furnishings; This Statute is not met as evidenced by:	I 164		

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I 164	Continued From page 4 Surveyor: DC007 Based on interview and review of records, the GHMRP failed to ensure that a policy to address the physical environment was include in its policy and procedure manual for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: On August 24, 2010, at approximately 1:05 p.m., interview with the house manager (HM) and review of the personnel policies and procedures manual failed to have a policy on physical environment, which covered cleaning the kitchen, and housekeeping inclusive of sorting and washing clothes.	I 164	Please see attached pages 27-31 of our Operations Manual with our operating Policy which outlines maintaining physical environment, which includes kitchen, Housekeeping and laundry. The manual was in the facility at the time of the survey.	9/15/10
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Surveyor: DC007 Based on interview and review of records, the GHMRP failed to establish and maintain a system that ensures a complete and accurate accounting of residents' funds that are entrusted to the facility for two of three residents included in the sample. (Resident's #2, and #3) The finding includes: On August 24, 2010, at approximately 2:20 p.m., a review of resident's #2 and #3's financial records revealed there were not enough receipts to verify what Resident's #2 and #3's money was being spent on. Interview with the House Manager on the same date at approximately 2:30	I 189	1189. Requested copies of current bank statements to verify resident's #s 2 and 3 accounting is balanced and receipt of vacation refund is available for review.	9/15/10

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I 189	Continued From page 5 PM revealed that all the residents' records could not be retrieved and that she did not have all the documents to justify the residents' expenditures/receipts. The GHMRP failed to have files detailing funds accounting for Resident's, #2 and #3's monies received and disbursed at the time of the survey.	I 189		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Surveyor: DC007 Based on record review and staff interview, the group home for the mentally retarded person's (GHMRP) failed to ensure all staff was provided a written job description for three (3) of eleven (11) records reviewed as required by this section. [DCW #2, LPN and the RN] The finding includes: Record review and interview with the GHMRP 's House Manager (HM) on August 24, 2010 at approximately 10:45 a.m. revealed three out of eleven staff was without a written job description in their personnel files. At the time of the survey, the GHMRP failed to ensure the availability of documents for review during inspection.	I 202	<i>Job descriptions for DCW #2, LPN and RN are in facility and available for review.</i>	<i>9/15/10</i>
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and	I 261		

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I 261	Continued From page 6 made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Surveyor: DC007 Based on interview and record review, the GHMRP failed to ensure records were available for inspection at all times by personnel of authorized regulator agencies for three of fourteen personnel records. (Psychiatrist, Nutritionist and the Qualified Mental Retardation Professional) The finding includes: On August 23, 2010, at approximately 9:30 a.m., during the entrance conference a request was made for various documents including the Human Rights Committee (HRC) minutes, contracts, nurses, and consultant files to be provided on August 24, 2010, by 11:00 a.m. Interview with the house manager (HM) on August 24, 2010, revealed that the aforementioned documents were in the main office. The documents arrived at approximately 11:30 a.m., however the Psychiatrist, Nutritionist and the Qualified Mental Retardation Professional's documents were not transported. The House Manager indicated she called the QMRP who informed her that he would send the documents shortly. The documents never arrived. At the time of the survey, the GHMRP failed to ensure the availability of documents for review during inspection.	I 261	<i>The personnel records for QMRP are in the facility and available for review please find attached the personnel records for nutritionist and psychiatrist.</i>	9/15/10
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of	I 379		

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Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.

This Statute is not met as evidenced by:
Surveyor: 19076
Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the three residents (Resident #1) included in the sample.

The findings include:

Review of the facility's incident reports on August 23, 2010, at approximately 9:00 a.m., revealed the following incidents were not reported as required:

1. On April 25, 2010, Resident #1 complained of abdominal pain. Continued review of the incident report revealed that the resident was transported via 911 to the emergency room. Further review revealed Resident #1 was admitted to the hospital on April 25, 2010 and discharged on April 29, 2010 with a diagnosis of abdominal ileus.
2. On November 30, 2009, Resident #1 was observed experience an episode of vomiting in the facility. Continued review of the incident

I 379

Please find attached a copy of our reporting list of all serious and reportable incidents, which was reviewed with QMRP's. Additionally all reports were entered in to the MEIS system, in accordance with DDS regulations.

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I 379	Continued From page 8 report revealed that the resident was transported via 911 to the emergency room and admitted for evaluation and treatment. During a face to face interview with the Licensed Practical Nurse (LPN) on August 23, 2010, at approximately 3:00 p.m, it was acknowledged the Department of Health/Health Regulation Licensure Administration (DOH/HRLA) had not been notified of the aforementioned incidents. There was no documented evidence that DOH/HRLA had been notified.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Surveyor: 19076 Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident for three of three residents in the sample. (Resident #1, #2 and #3) The findings include: 1. Review of Resident #1, #2 and #3's medical	I 401		

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I 401 Continued From page 9
 record on August 23, 2010 at approximately 1:00 p.m., revealed no evidence of a psychological assessment.

During a face to face interview with the Licensed Practical Nurse (LPN) on August 23, 2010 at approximately 1:25 p.m., it was acknowledged Resident #1, #2 and #3's psychological assessment was not in the medical record.

There was no evidence of professional services including psychological assessments that identified the diagnosis, evaluation and developmental levels and needs for the residents.

2. Review of Resident #1's Primary Care Physician's (PCP's) orders on August 23, 2010 at approximately 1:30 p.m., revealed "if no bowel movement after third day notify [PCP]". Review of Resident #1's Bowel Tracking Data Collection form on August 23, 2010 at approximately 1:40 p.m., revealed that on July 1, 5, and 8, 2010, there was no recorded data.

During a face to face interview with the LPN and House Manager (HM) on August 23, 2010 at approximately 1:45 p.m., it was acknowledged Resident #1's bowel movement data for July 1, 5, and 8, 2010, was not recorded on the Bowel Tracking Data Collection form.

There was no evidence of that all services designed to prevent deterioration or further loss of function by the resident was conducted as ordered by the PCP.

I 401

① QMRP will request from DDS Service Coordinator a referral for a psychological assessment to be done on residents #1s 1, 2 & 3. However as a matter of practice at the ISP the team determines if an annual psychological assessment is needed or done.

② QMRP will issue a written reprimand to staff for the missing documentation. # Additionally our Facility Manager will review documentation weekly to ensure complete and accurate documentation.

9/15/10

9/15/10