

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

PRINTED: 08/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

A recertification survey was conducted from July 27, 2011 through July 28, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six males with various levels of intellectual and developmental disabilities.

The findings of the survey were based on observations at the group home, one day program, interviews with clients and staff and the review of clinical and administrative records, including incident reports.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received continuous active treatment, for one of the three clients in the sample. (Client #3)

The finding includes:

Client #2 did not participate in his ambulation program, as evidenced by the following:

Observations on July 27, 2011, at 8:11 a.m.,

W 000

Received 8/2/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 249 Staff was retrained on 07-30-11 on program 07-30-11

implementation and documentation with emphasis on the importance of implementing programs consistently. The QIDP and House Manager will monitor staff everyday for one month and then once per week, then monthly and as needed to ensure that staff is knowledgeable about all individual programs. In future, QIDP will continue to monitor periodically that above mentioned issue do not arise.

See Attachment "A1" - "A2"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Program mgr.	(X6) DATE 8/26/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249 Continued From page 1

revealed Client #2 being assisted from the dining room chair into his wheelchair. Upon the client's arrival from day program at 4:38 p.m., staff was observed propelling the client into his bedroom for personal hygiene. Minutes later, he was propelled to the dining room table for snack, table top activities, and dinner. He was transferred to a regular dining room chair.

In an interview on July 27, 2011, at 4:45 p.m., staff indicated that the client could ambulate short distances, twice a day (during evening programming).

Review of Client #2's individual program plan (IPP) dated October 18, 2011, on July 28, 2011, at 9:30 a.m., revealed a program objective which stated, "[the client] will ambulate at least 10 feet with 50% physical assistance, two times daily (4:30 p.m. and 6:30 p.m.). Review of the client's data sheet on July 28, 2011, at approximately 10:00 a.m., revealed that the staff documented on July 27, 2011, that the client required physical assistance on both (4:30 p.m. and 6:30 p.m.) trials. Staff, however, had not been observed implementing the program that evening.

On July 28, 2011, at 10:10 a.m., in an interview with the direct support staff who was assigned to Client #2 on the evening of July 27, 2011, revealed that the client ambulated after he completed his dinner as he prepared for his evening hygiene. The surveyor however, had been in the facility until 7:20 p.m., and did not see the program implemented

The staff failed to provide the client with the opportunity to participate in his ambulation

W 249

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W 249 Continued From page 2 program.

W 249

W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

W 262

The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of the three clients in the sample. (Client #1)

The findings include:

Review of Client #1's medical chart on July 27, 2011, beginning at 1:35 p.m., revealed a physician's order (POS) dated January 1, 2011. The POS revealed an order for Ativan 3 mg, by mouth one and half hour, prior to an ear, nose and throat (ENT) appointment scheduled February 4, 2011.

Review of Client #1's medication administration record on July 27, 2011, at 3:00 p.m., confirmed that the client received the aforementioned sedation.

Interview with the qualified intellectual disabilities professional (QIDP) on July 28, 2011, at approximately 10:40 a.m., revealed that Client #1 received the sedation to address his non-compliance prior to medical appointment.

After the primary care physicians determined the need to sedate client #1 prior to his ENT appointment, QIDP held a teleconference with the legal guardian, HRC chairperson, facility RN and Quality assurance. The team agreed with the physician order and the medical legal guardian signed the consent for sedation. It is our policy to get HRC approval for all restrictive measures. However, when restrictive measures are urgently needed, approval is sought through a teleconference with HRC members and signatures are obtained at earliest to file in record book. However, the signed consent was present in the record at the time of the survey. But, it was not signed by the H.R.C chairperson who had given the teleconsent. This was corrected on 08-16-11 and paper was filed in A.M.R. In future, QIDP will make sure to obtain signature in timely manner and also check the books monthly during note review to avoid such errors.

08-16-11

(See Attachment "B1"- "B2")

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W 262 Continued From page 3
Further interview indicated that the HRC discussed the client's sedation. Minutes taken at meetings of the facility's HRC for the period August 2010 through May 2011, failed to ensure that the HRC approved the use of the sedation for Client #1.

W 381 483.460(I)(1) DRUG STORAGE AND RECORDKEEPING

The facility must store drugs under proper conditions of security.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed store medications under proper conditions of security.

The finding includes:

On July 27, 2011, at 4:53 p.m., the medication nurse retrieved a pitcher of water from the kitchen refrigerator and a bottle of Pepto-Bismol was observed in the refrigerator. On July 28, 2011, at 9:46 a.m., the same bottle of Pepto Bismol was observed.

On July 28, 2011, at 10:40 a.m., the facility's licensed practical nurse (LPN) was informed of that the bottle of Pepto Bismol was in the refrigerator. She further observed that the bottle had no pharmacy label. At 11:02 a.m., the LPN informed the surveyor that the bottle of medication belonged to the house manager. She further indicated that the house manager was not feeling well the day before and mistakenly left the medication in the refrigerator.

W 262

W 381 Staff were retrained on 07-30-11 by the Director of Nursing on storage of all medication in the facility. Staff were advised to lock their personal medications in their pocketbook/bag where it cannot be accessed by the individuals or any other person in the house. In future, the QIDP and House Manager will monitor on a daily basis the refrigerator, pantry and kitchen cabinets to ensure that no drugs are lying around.

(See Attachment "A1"- "A2")

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
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1000	INITIAL COMMENTS A licensure survey was conducted from July 27, 2011 through July 28, 2011. A sample of three residents was selected from a population of six men with various intellectual and developmental disabilities. The findings of the survey were based on observations, interviews with staff one day program, as well as a review of resident and administrative records, including incident reports.	1000	
1206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home For Persons with Intellectual Disabilities (GHPID) failed to show evidence of a physician's certification that documented a health inventory had been performed, for one (1) of seven (7) consultants records reviewed. (Consultant #4 Speech and Language Pathologist) The finding includes: On July 28, 2011, beginning at approximately 12:10 p.m., review of the personnel records revealed that one of seven consultants did not have a current health certificate, the Speech and Language Pathologist nor was there evidence	1206	The consultant's current health certificate was obtained on 08/04/11 and filed. 08-04-11 Please see attachment "C" In Future, HR Director will send reminders to all consultants 2 months prior to expiration of their health certificate. HR Director will make sure that above information is obtained and filed. Please see attachment "C"

Health Regulation & Licensing Administration

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

STATE FORM

TITLE

(X5) DATE

ORWS11

If continuation sheet 1 of 4

Health Regulation & Licensing Administration

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I 206	Continued From page 1 they had been certified free from communicable diseases. This was acknowledged by the agency Human Resources Director (HRD) on the same day at approximately 3:00 p.m.	I 206		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents received habilitation and assistance as prescribed in their Individual Support Plan, for two of the four residents in the sample. (Residents #1 and #3) The findings include: Resident #2 did not participate in his ambulation program, as evidenced by the following: Observations on July 27, 2011, at 8:11 a.m., revealed Resident #2 being assisted from the dining room chair into his wheelchair. Upon the resident's arrival from day program at 4:38 p.m., staff was observed propelling the resident into his bedroom for personal hygiene. Minutes later, he was propelled to the dining room table for snack, table top activities, and dinner. He was transferred to a regular dining room chair. In an interview on July 27, 2011, at 4:45 p.m., staff indicated that the resident could ambulate short distances, twice a day (during evening programming).	I 422	Staff was retrained on 07-30-11 on program implementation and documentation with emphasis on the importance of implementing programs consistently. The QIDP and House Manager will monitor staff everyday for one month and then once per week, then monthly and as needed to ensure that staff is knowledgeable about all individual programs. In future, QIDP will continue to monitor periodically that above mentioned issue do not arise. See Attachment "A1"- "A2"	07-30-11

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I 422	Continued From page 2 Review of Resident #2's individual program plan (IPP) dated October 18, 2011, on July 28, 2011, at 9:30 a.m., revealed a program objective which stated, "[the resident] will ambulate at least 10 feet with 50% physical assistance, two times daily (4:30 p.m. and 6:30 p.m.). Review of the resident's data sheet on July 28, 2011, at approximately 10:00 a.m., revealed that the staff documented on July 27, 2011, that the resident required physical assistance on both (4:30 p.m. and 6:30 p.m.) trials. Staff, however, had not been observed implementing the program that evening. On July 28, 2011, at 10:10 a.m., in an interview with the direct support staff who was assigned to Resident #2 on the evening of July 27, 2011, revealed that the resident ambulated after he completed his dinner as he prepared for his evening hygiene. The surveyor however, had been in the facility until 7:20 p.m., and did not see the program implemented The staff failed to provide the resident with the opportunity to participate in his ambulation program.	I 422	
I 500	3523.1 RESIDENT'S RIGHTS 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. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with	I 500	

Health Regulation & Licensing Administration

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I 500	Continued From page 3 Intellectually Disabilities (GHPID) 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 8, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectually disabilities, for one of the three residents in the sample. (Resident #1) The findings include: Review of Resident #1's medical chart on July 27, 2011, beginning at 1:35 p.m., revealed a physician's order (POS) dated January 1, 2011. The POS revealed an order for Ativan 3 mg. by mouth one and half hour, prior to an ear,nose and throat (ENT) appointment scheduled February 4, 2011. Review of Resident #1's medication administration record on July 27, 2011, at 3:00 p.m., confirmed that the resident received the aforementioned sedation. Interview with the qualified intellectual disabilities professional (QIDP) on July 28, 2011, at approximately 10:40 a.m., revealed that Resident #1 received the sedation to address his non-compliance prior to medical appointment. Further interview indicated that the HRC discussed the resident's sedation. Minutes taken at meetings of the facility's HRC for the period August 2010 through May 2011, failed to ensure that the HRC approved the sue of the sedation for Resident #1.	I 500	After the primary care physicians determined the need to sedate client #1 prior to his ENT appointment, QIDP held a teleconference with the legal guardian, HRC chairperson, facility RN and Quality assurance. The team agreed with the physician order and the medical legal guardian signed the consent for sedation. It is our policy to get HRC approval for all restrictive measures. However, when restrictive measures are urgently needed, approval is sought through a teleconference with HRC members and signatures are obtained at earliest to file in record book, However, the signed consent was present in the record at the time of the survey. But, it was not signed by the H.R.C chairperson who had given the teleconsent. This was corrected on 08-16-11 and paper was filed in A.M.R. In future, QIDP will make sure to obtain signature in timely manner and also check the books monthly during note review to avoid such errors. See Attachment "B1- B2"	08-16-11