

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/16/2011
NAME OF PROVIDER OR SUPPLIER  HEALTH CARE RESOURCES		STREET ADDRESS, CITY, STATE, ZIP CODE 2608 RITTENHOUSE ST, NW WASHINGTON, DC 20015		
(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
1 000	INITIAL COMMENTS  A licensure survey was conducted on June 16, 2011. A sampling of two residents was selected from a residential population of four women with various degrees of intellectual and/or developmental disabilities.	1 000	<i>Received 7/1/2011</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St, N.E. Washington, D.C. 20002	
1 043	3502.2(c) MEAL SERVICE / DINING AREAS  Modified diets shall be as follows:  (c) Reviewed at least quarterly by a dietitian.  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 ensure that the resident's modified diet was reviewed at least quarterly by a dietitian for one of the two residents included in the sample. (Resident #2)  The finding includes:  Interview with the Program Manager/ Qualified Mental Retardation Professional on June 16, 2011 at approximately 10:10 a.m. revealed Resident #2 was prescribed a 1600 calorie, low fat, low cholesterol diet. Further interview revealed the resident's weight was be monitored monthly. Record review on June 16, 2011 at approximately 1:10 p.m. revealed only one documented nutritional assessment dated November 29, 2010.  There was no documented evidence GHPID ensured the resident's modified diet was reviewed at least quarterly.	1 043	<b>1. Corrective Action:</b> Resident #2 receives her Nutritional Services under the Waiver from another agency called Total Care. The service coordinator at the Department on Disability Services and the Program Director of HealthCare Resources have approached the provider of Nutritional Services to complete the assessments and reports and submit them in a timely manner.  <b>2. If Other Residents are Impacted, Action to Correct/Prevent Similar Deficiency:</b> The Program Management team and the Nursing team will continue to monitor and coordinate the services needed by each individual to meet their health care needs and ensure their well being.  <b>3. Responsible Persons:</b> President, Program Director and RN	July 31 2011

Health Regulation & Licensing Administration

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

*[Signature]*

TITLE *President*

(X6) DATE

*7/1/11*

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1 090	Continued From page 1	1 090		
1 090	<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: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for two of two residents in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>Observation and interview with the facility Lead Counselor (LC) on June 16, 2011, beginning at 3:25 p.m., revealed the following:</p> <p>Interior</p> <ol style="list-style-type: none"> <li>1. The ceiling light fixture in the laundry room had a missing globe;</li> <li>2. The light bulb in the kitchen refrigerator was not working;</li> <li>3. The wooden porch railing outside of Resident #2's bedroom was loose and contained exposed nails; and</li> <li>4. The stone walk way near the driveway had several loose stones.</li> </ol> <p>In an interview with the LC and the Administrator</p>	1 090	<p><b>1. Corrective Action:</b> As indicated by the DOH monitor, the group home at 2608 Rittenhouse Street, NW, Washington D.C., the GHPID is maintained in "a safe, clean, orderly, attractive and sanitary manner..." The 4 concerns identified by the DOH monitor have been addressed immediately by the President of HealthCare Resources: 1. The missing globe in the light fixture of the laundry room has been replaced; 2. A new light bulb for the refrigerator was bought on the same day of the monitor's visit; 3. The wooden porch railing has been fastened and loose nails removed; 4. The loose stones in the driveway have been fixed.</p> <p><b>2. If Other Residents are Impacted, Action to Correct/Prevent Similar Deficiency:</b> To ensure the continued safety and cleanliness of the house, the residential manager and program manager will continue to inspect all the house weekly, document and report findings to the President for remedial action.</p> <p><b>3. Responsible Persons:</b> President, Program Director</p>	7/31/11

Health Regulation & Licensing Administration

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I 090	Continued From page 2 on June 16, 2011 at approximately 4:30 p.m., it was acknowledged the above-cited deficiencies were present at the time of the survey.	I 090		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (e) Nursing:  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 the provision of nursing services in accordance with the assessed needs of one of two residents in the sample. (Resident#1).  The finding includes:  The GHPID nursing staff failed to inform Resident #1's primary care physician (PCP) of the Debrox treatment recommended by the Ears, Neck and Throat (ENT) specialist as evidenced by:  Observation on June 16, 2011 at approximately 6:55 am revealed Resident #1 was walking around the living room of the facility pulling on her lower left earlobe.	I 395	<p><b>1. Corrective Action:</b> The Nurse acted immediately in regard to the need of Debrox for Resident # 1. She has been administered the ear drops as ordered, and monitored twice a day. She is presently free from the wax impaction, and will be returning to the ENT and PCP as soon as appointments can be arranged by the RN/LPN team</p> <p><b>2. If Other Residents are Impacted, Action to Correct/Prevent Similar Deficiency:</b> The nursing team has been diligently working on each health care rick and issue for each of the individuals at the group home, and positive results have been noticed by internal monitors such as the Program Director, as well as by monitors from the Department on Disability Services.</p> <p><b>3. Responsible Persons:</b> LPN, RN &amp; Program Director</p>	6/30/11

Health Regulation & Licensing Administration

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I 395	Continued From page 3  Review of Resident #1's ENT consult dated May 11, 2011 on June 16, 2011 at approximately 1:00 p.m., revealed a recommendation for Debrox, four (4) to six (6) drops every night in the left ear four (4) times a day for thirty (30) days for severe wax impaction and to return to the ENT clinic for re-evaluation on June 7, 2011.  Review of Resident #1's ENT consult dated June 7, 2011 on June 16, 2011 at approximately 1:10 p.m., revealed the resident's left ear was impacted with hard wax and a recommendation was made "Please do not send back unless she (Resident #1) has been given the Debrox ear drops".  During a face to face interview with the LPN on June 16, 2011 at approximately 1:25 p.m. it was acknowledged Resident #1's PCP was not made aware of the recommendation by the ENT specialist and the Debrox ear drops were never ordered for cerumen removal.	I 395		
I 407	<b>3520.9 PROFESSION SERVICES: GENERAL PROVISIONS</b>  Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for two of the two residents in the sample. (Residents #1 and #2)	I 407	<b>1. Corrective Action:</b> HealthCare Resdurses has contracted with another provider agency for skilled nursing services to ensure that the residents receive the most effective care. The RN will complete the Quarterlies and make them available in the residents' medical books in a timely manner. The Nurses have completed Monthly health reviews and summaries and these are available for inspection.	7/31/11

Health Regulation & Licensing Administration

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I 407	Continued From page 4  The findings include:  1. Review of Resident #1's medical record on June 16, 2011, at approximately 11:05 a.m., revealed a nursing assessment dated August 12, 2010. Further record review revealed no evidence of quarterly nursing reviews for November 2010, February 2011 and May 2011.  2. Review of Resident #2's medical record on June 16, 2011, at 12:10 p.m., revealed a nursing assessment dated October 06, 2010. Further record review revealed no evidence of quarterly nursing reviews for January 2011 and April 2011.  Interview with the facility's President on June 16, 2011, at approximately 2:00 p.m., revealed that a registered nurse (RN) should complete quarterly nursing exams. She further indicated the facility's former RN had resigned and there was a new RN assigned to the facility and acknowledged there were no nursing quarterly reviews for Residents #1 and #2.	I 407	<b>2. If Other Residents are Impacted, Action to Correct/Prevent Similar Deficiency:</b> The nurses have completed monthly reviews. They will also complete comprehensive quarterly reviews and assessments. Their quarterly reports will be filed in a timely manner. As indicated by the DOH monitor a new RN has taken charge, and has begun the review of all individual records, and is committed to upholding the best health care standards.  <b>3. Responsible Persons:</b> RN and Program Director	