

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2011
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019
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(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) COMPLETION DATE
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<p>W 000 INITIAL COMMENTS</p> <p>A recertification survey was conducted from September 15, 2011 through September 16, 2011. A sampling of two clients was selected from a population of four males with various intellectual disabilities. The survey was initiated as a fundamental survey, however, due to a finding of unreported and uninvestigated injuries of unknown origin, on September 16, 2011, at 9:32 a.m., the survey was extended in the Condition of Client Protections.</p> <p>The findings of the survey were based on observations and interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident and investigation reports.</p> <p>[Qualified mental retardation professional(QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	<p>W 000</p> <p><i>10/28/11</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
<p>W 104 483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the governing body failed to maintain general operating direction over the facility, as evidenced by the deficiencies cited throughout this report, for two of two clients in the sample (Clients #1 and #2).</p> <p>The findings include:</p>	<p>W 104</p> <p>W104 Reference response to W149. QIDP/Director of Programs and Incident Management Coordinator will ensure staff are retrained on the incident management reporting procedures and protocol for incidents. QIDP will monitor incidents monthly to ensure compliance. In the event that policies for incident reporting are not followed, corrective action as appropriate will ensue.</p>	<p>10/20/2011 -Ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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<p>W 104 Continued From page 1 The governing body failed to ensure its incident management policy was implemented (See W149).</p> <p>W 111 483.41D(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure treatment records were accurately maintained for one of two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>[Cross refer to W153.1]. The review of unusual incidents on September 15, 2011, at 10:30 a.m., revealed that on September 15, 2010, at 12:00 p.m., a direct care staff observed Client #1 to have a knot over his right eye and a right black eye of unknown origin.</p> <p>Interview with the designated registered nurse (DRN) on September 15, 2011, at 4:43 p.m., revealed that on September 15, 2010, the primary care physician (PCP) was notified of Client #1's black eye and provided monitoring and treatment instructions. Further discussion with the DRN on September 16, 2011, at 4:17 p.m., indicated that the client's eye was monitored on the September 17, 18, and 19, 2010, however, there was no documentation. According to the DRN, the PCP evaluated the client's eye on September 20, 2010. On September 16, 2011, at 4:22 p.m.,</p>	<p>W 104</p> <p>W 111</p> <p>W111</p>	<p>The PCP has provided the full note of the assessment for Client #1 medical record. The Delegating Registered Nurse (DRN) will monitor the individual's documentation and follow up with the PCP as necessary for timely delivery of documentation. Additionally, the DRN has received training from the Director of Health Services on appropriate documentation of changes in individual's status. Monthly nursing reviews of medical records will be conducted by the DRN. In the event that the treatment records are not accurately maintained, corrective action as appropriate will ensue.</p>	<p>10/15/2011 -Ongoing</p>

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W 111	<p>Continued From page 2</p> <p>Interview with the director of nursing revealed that when a client had has an injury, the injury should be monitored until it is resolved.</p> <p>Record review on September 16, 2011, at 10:22 a.m., revealed that on September 16, 2010, the PCP was notified that Client #1's right eye was swollen. The PCP ordered a facial x-ray, and further instructed to monitor the client until his medical appointment on September 20, 2010, four days later. The review of an e-mail from the facility's residential director, dated September 16, 2010, revealed that the client was uncooperative and the x-ray could not be performed. On September 16, 2011, at 4:24 p.m., continued record review, however, confirmed that on September 17, 18, or 19, 2010, there was no documentation to describe monitoring, and no treatment ordered for Client #1's right black eye.</p> <p>Record review on September 16, 2011, at 10:37 a.m., revealed that the PCP evaluated Client 1's black eye on September 20, 2010, and stated that a "full note" of the assessment would be provided for the client's record. On September 16, 2011, at 4:27 p.m., the DRN confirmed that the aforementioned "full note" was not not available. At the time of the survey, the facility failed to ensure a record keeping system that accurately documented Client 1's health care after his right eye injury of unknown origin.</p>	W 111	
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p>	W 140	

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W 140	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a complete accounting of clients' personal funds, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and review of Client #1's financial records on September 16, 2011, at 2:45 p.m., revealed that the facility assisted the client with maintaining his finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) monthly.</p> <p>Review of Client #1's bank statements on September 16, 2011, beginning at 2:45 p.m., revealed a withdrawal of \$100.00 on August 25, 2011, and another withdrawal of \$100.00 on September 20, 2010. Additional review revealed no receipts to show how the money was spent. Interview with the QIDP on September 16, 2011, at 3:00 p.m., revealed that she would retrieve the receipts from the financial department; however, at the time of the survey, the receipts were not presented for review.</p>	W 140	<p>W 140</p> <p>The outstanding bank receipts for Client #1 have been secured and placed on file in their financial record book in the administrative office. Review of the records indicated that the receipts for the \$100.00 August 25, 2010 (reflected as 2011 in the deficiency report) withdrawal and \$100.00 for September 20, 2010 were retrieved from the financial records that were being audited in the financial office and faxed to DOH on 9/18/2011. QIDP/Program Manager will complete monthly reconciliation of all individual finances to ensure that client receipts are timely placed in their financial record books. Director of Programs and Accounts Receivables Specialist will perform monthly monitoring to ensure compliance. In cases when the Program Manager does not maintain the financial record in accordance with agency procedure, corrective action as appropriate will ensue.</p>
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by:</p>	W 149	
<p>9/18/2011- Ongoing</p>			

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W 149	<p>Continued From page 4</p> <p>Based on interview and record review, the facility failed to implement its policies to ensure the health and safety of two of two clients in the sample (Clients #1 and #2).</p> <p>The findings include:</p> <p>I. [Cross-refer to W153.] The facility failed to implement its established policy for reporting all injuries of unknown origin and allegations of abuse.</p> <p>On September 16, 2011, beginning at 3:37 p.m., review of the unusual incident reports revealed the following information concerning reporting requirements.</p> <ul style="list-style-type: none"> - Incident reports are developed by the staff closest to the issue and are faxed to the agency's administrative assistant by noon of the following business day. - The administrative assistant provides copies of the incident report to the relevant QIDP and the incident management coordinator (IMC) for their review within 12 hours of receiving the report. - The IMC directs the administrative assistant to submit the reviewed report, and if necessary, edited report to the relevant parties, including the Department of Health (DOH) within 24 hours of the incident. - The administrative assistant makes a notification call to the DOH alerting them that the incident report has been sent. <p>Review of the unusual incident reports on</p>	W 149	<p>W 149 See Response to W 149 on page 6 of 21.</p>	

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W 149	<p>Continued From page 5</p> <p>September 16, 2011, beginning at 9:15 a.m., revealed the following information concerning notification of incidents:</p> <p>A. On September 15, 2011, at 12:00 a.m., a staff discovered Client #1 had a right swollen black eye. Continued record review revealed the residence director (RD) and the medication nurse were notified on September 15, 2011, at 7:30 a.m. and 8:00 a.m., respectively. Continued review of the report revealed that the agency's director and incident manager were notified after 7:30 a.m. (more than seven hours after the injury was observed.)</p> <p>B. On October 6, 2010, at 8:45 p.m., a staff discovered Client #2 to have shoulder bruises of unknown origin. Continued record review revealed the RD and the designated registered nurse (DRN) were notified on October 6, 2010 at 8:50 p.m., at at 9:00 p.m. Further review of the report failed to evidence that the agency's director and incident manager were notified.</p> <p>C. On February 13, 2011, at 3:00 a.m., a staff discovered Client #2 had a black eye of unknown origin. Continued record review revealed that the RD was notified on February 13, 2011, at 7:45 a.m. The record revealed that the QIDP was notified on February 13, 2011 (time unspecified) and that the DRN was notified on February 14, 2011 (time unspecified). Further review of the report revealed that the agency's director and incident manager were notified.</p> <p>D. On November 16, 2010 at 2:40 p.m., Client #2 was allegedly verbally abused by his 1:1 staff from the group home, while he was at his day</p>	W 149	<p>W 149</p> <p>A. Review of records indicate that Client #1's eye was noted by staff as being swollen at 12am however, was not noted as being black until he awoke the following morning. B & D. IMC will retrain all staff on the incident management reporting policies and procedures and policies incident management to ensure that staff are aware of the policies that govern incident management both internally and externally (with an emphasis on timely and required notification).</p> <p>Response to W 149 continued on paged 7 of 21.</p>
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W 149	Continued From page 6 program. According to the RD, incidents that occur at the day program should be reported by the day program. There was no evidence that the Department of Health was notified of the incident. Further review of the agency's incident management policy on September 16, 2011, at 3:55 p.m., revealed, "the Department of Health also routinely requires that injuries of unknown origin, major or minor, be reported within 24 hours, as well as all emergency room visits." At the time of the survey, there was no evidence that the facility notified the DOH of the aforementioned injuries of unknown origin and allegations of abuse in accordance with its established written policy. ii. [Cross refer to W154] The facility failed to implement its policy to ensure that all injuries of unknown origin and allegations of abuse were internally investigated. A. The review of the facility's Incident management policy (IMP) on September 16, 2011, at 3:39 p.m. revealed a full investigation of the incident must begin within 12 hours and be forwarded within five days. It should be noted that on September 16, 2011, at 10:40 a.m., interview with the QIDP, and the review of records revealed no investigation reports were available for Client #2's injuries of unknown origin, dated October 6, 2010 (shoulder bruises) and February 13, 2011 (black eye). Further discussion with the QIDP on September 16, 2011, at 4:40 p.m., revealed no evidence that investigations of the incidents were completed.	W 149	W 149 continued C. Further investigation into the incident that occurred on February 13, 2011 for client #2 was not reported to the IMC, although the record indicated that notification was made to the Director and IMC. The Incident report was reportedly faxed to the main office, since the time of this incident a designated fax line has been established to streamline the receipt of incident reports during both business and non-business hours. In addition to routine on site observation, the Program Manager, QIDP and DRN will monitor the documentation for unusual incidents to ensure that all incidents are managed in accordance with established policies and procedures. In the event that policies for incident management, corrective action as appropriate will ensue.	10/20/2011 -Ongoing	

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W 149	Continued From page 7 [Note: The agency incident management policy stated "When major or minor injuries are discovered, investigations are conducted to try to ascertain the origin. Follow-up is recommended to address issues uncovered and to prevent reoccurrences."]	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown origin and allegations of abuse were reported immediately to the administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA), for two of two clients in the sample. (Clients #1 and #2) The findings include: A. On September 15, 2011, at 9:25 a.m., interview with the residential director (RD) revealed that the following usual incidents had occurred: 1. On September 15, 2010 (10:00 a.m.), Upon checking Client #1, an overnight staff discovered that he had "a black eye with a goose egg knot over his eye brow area", which was determined to be of unknown origin.	W 153	W 153 A 1-2 & B 1-2: Cross Reference response to W 149.	

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W 153	<p>Continued From page 8</p> <p>Interview with the RD and the qualified intellectual disabilities professional (QIDP) on September 15, 2011, at 10:30 a.m., revealed that the Department of Health (DOH) should have been informed of Client #1's injury. The review of the incident report on September 15, 2011, at 9:42 a.m., and of the corresponding investigative report dated September 21, 2010, on September 16, 2011, at 12:17 p.m., however, failed to evidence that the client's injury had been reported.</p> <p>2. Further discussion with the RD on September 15, 2011, at 9:40 a.m., revealed that on November 16, 2010 at 2:40 p.m., Client #2 was allegedly verbally abused by his residential 1:1 staff, while he was at his day program. According to the RD, the incident that occurred at the day program should be reported by the day program.</p> <p>Interview with the QIDP on September 15, 2011, at 10:47 a.m., revealed that she would follow-up with the administrative office to determine if the incident was reported to DOH. Interview with the QIDP on September 16, 2011, at 10:40 a.m., confirmed that the incident had not been reported to the DOH.</p> <p>On September 16, 2011, at 10:42 a.m., review of the verbal notification for the incident confirmed that the aforementioned allegation of verbal abuse of Client #2 had not been reported to the DOH.</p> <p>B. On September 15, 2011, at 3:40 p.m., and 3:53 p.m. respectively, review of unusual incidents revealed that Client #2 sustained two</p>	W 153	<p>See response to W 153 on Page 8 of 21.</p>

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W 153	<p>Continued From page 9</p> <p>injuries of unknown origin, as evidenced below.</p> <p>1. October 6, 2010 (8:45 p.m.): While dressing Client #2 for his p.m. care, the client's 1:1 staff discovered a bruise on each side of his shoulders. Further record review, however, revealed the UIR did not include a description of the size of the client's bruises. Continued review of the incident report failed to provide evidence that the DOH had been notified of the incident.</p> <p>Interview with the QIDP on September 15, 2011, at 4:45 p.m., and on September 16, 2011 at 1040 a.m., confirmed that the incident had been not been reported to the DOH.</p> <p>2. February 13, 2011 (3:00 a.m.): Staff reported that Client #2 was discovered with a black eye (left lower eye), while assisting him from the living room to his bedroom. On September 15, 2011, at 3:45 p.m., continued review of the incident report failed to provide evidence that the DOH had been notified of the incident.</p> <p>Interview with the QIDP on September 16, 2011, at 1040 a.m., confirmed that the incident had been not been reported to the DOH.</p> <p>[Note: Post survey review of reported unusual incidents on September 19, 2011 revealed that the aforementioned incidents had not been reported.]</p>	W 153	See response to W 153 on Page 8 of 21.	
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p>	W 154		

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W 154	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all allegations for one of two clients in the sample (Client #2).</p> <p>The findings include:</p> <p>The facility failed to investigate injuries of unknown origin for Client #2.</p> <p>a. [Cross refer to W153.B1] On September 15, 2011, at 3:40 p.m., review of an unusual incident dated October 6, 2010, at 8:45 p.m., revealed the 1:1 staff discovered Client #2 had bruises on each side of his shoulders. Documentation of verbal notifications revealed that on the same day at 8:50 p.m., and 9:00 p.m. respectively, the RD and the designated registered nurse (DRN) were notified.</p> <p>Interview with the QIDP on September 15, 2011, at 4:45 p.m., revealed she would obtain the investigation report for Client #2's bruises on his shoulders. On September 16, 2011, at 10:40 a.m., further discussion with the QIDP, and the review of available records revealed no investigation report for the incident.</p> <p>At the time of the survey, there was no evidence the facility conducted an investigation of Client #2's shoulder bruises of unknown origin.</p> <p>b. [Cross refer to W153.B2]. On September 15, 2011, at 3:53 p.m., review of an unusual incident dated February 13, 2011 (3:00 a.m.), revealed staff discovered Client #2 had a black eye (under his left eye), as he was assisted to his room.</p>	W 154	<p>W 154</p> <p>a-b: Review of the records indicate that continuous training on incident investigation policies and procedures and follow up has occurred with the QIDP, DRN and Program Manager for Client #2 since the occurrence of the incidents on October 6, 2010 and February 13, 2011. IMC will continue to provide ongoing training to all Certified Investigators to enforce implementation of all investigative and incident follow-up procedures. All allegations will be thoroughly investigated with findings reported per incident management policy and procedure (DOH within 5 days and DDS within 25 days of the incident). Investigation reports will be maintained on file in the main office as well as the applicable individual record.</p>
		(X5) COMPLETION DATE 10/20/2011 -Ongoing	

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W 154	Continued From page 11 Review of the unusual incident report on September 15, 2011, at 3:55 p.m., revealed on February 13, 2011, at 7:45 a.m., the residential director was notified. Further review of the unusual incident revealed the QIDP and the DRN were notified on February 13, 2011, and February 14, 2011, respectively. however the record failed to document a time of day for the notifications. Interview with the QIDP on September 15, 2011, at 4:45 p.m., revealed the administrative office would be contacted to obtain the investigation report for Client #2's black eye; however, the facility failed to provide evidence that Client #2's black eye was investigated. At the time of the survey, they was no evidence the facility had conducted an investigation of Client #2's black eye of unknown origin.	W 154	See response to W 154 on page 11 of 21.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for one of the two clients in the sample. (Client #2) The findings include: 1. [Cross refer to W249]. The facility's qualified	W 159	See response to W 159 on page 13 of 21.	

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W 159	Continued From page 12 intellectual disabilities professional (QIDP) failed to ensure Client #2 received continuous active treatment. 2. The QIDP failed to ensure the primary care physician (PCP) was notified of a new medication prescribed by the neurologist for Client #2. Observation of the medication administration on September 15, 2011, at 6:06 p.m., revealed the trained medication employee (TME) administered Cogentin to Client #2. Moments later, review of Client #2's medication administration records (MARS), revealed that the client began the aforementioned medication on September 7, 2011. Continued review revealed the neurologist wrote a prescription for Cogentin on August 25, 2011, however the medical record revealed no evidence that the primary care physician (PCP) had counter-signed the neurologist prescription. Interview with the registered nurse (RN) on September 19, 2011, at approximately 11:30 a.m., revealed that the PCP had agreed with the prescription, however failed to write or order the prescribed medication for Client #2. The facility failed to evidence that the PCP was made aware of the aforementioned medication prescribed by the neurologist.	W 159	W 159 1. Unable to respond deficiency for W249 not included in the statement of deficiency report. 2. The PCP was made aware of prescription by the neurologist for Client #2 via phone and gave his approval. Consult sheet has been signed by the PCP. In the future, the DRN will document telephone approval by PCP prior to obtaining signature on the consult sheet.	10/15/2011 -Ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each staff was provided continuing and effective training to perform duties effectively, efficiently and competently for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> [Cross refer to W455]. The facility failed to ensure staff were effectively trained on infection control. The facility failed to ensure that each staff was effectively trained to provide 1:1 supervision for Client #2 in accordance with his behavior support plan (BSP). <p>On September 15, 2011, at 8:30 a.m., the direct support staff introduced herself as Client #2's one to one staff. At the same time, the one to one staff was observed in the kitchen while the client was outside sitting on the deck. Approximately two minutes later, Client #2's one to one staff went outside and stood next to the client. During this time, the one to one staff was observed walking back and forth into the house and back to the deck as the client sat outside on the deck. At 9:07 a.m., a transportation van arrived to the facility, the one to one staff then assisted the client onto the van.</p> <p>Observation at the day program beginning at 10:50 a.m., revealed that the residential one to one staff serves as Client #2's one to one staff at his day program. Further observation at 10:56 a.m., revealed the day program staff engaging</p>	W 189	<p>W 189</p> <ol style="list-style-type: none"> Cross Reference Response to W455 QIDP has met with Behaviorist to clarify the whether client #2 one on one should be – "arms length or within eyesight". The specific requirements for the one to one have been clarified as within sight. Client#2's BSP has been revised to reflect "within sight". QIDP, RN, Program Manager and all 1:1 staff have been retrained on the revisions to Client# 2's BSP to ensure their awareness and/or consistency with 1:1 responsibilities. QIDP will periodically monitor 1:1 to ensure compliance. In the event that the BSP is not followed, corrective action as appropriate will ensue. 	<p>10/20/2011 -Ongoing</p> <p>10/7/2011 -Ongoing</p>

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W 189	Continued From page 14 and prompting the client to participate in active treatment. At 11:03 a.m., the client walked away from the day program staff and sat at the opposite end of the room. Several seconds later, the one to one staff walked over and sat next to the client. Observation of the medication administration on September 15, 2011, at 6:06 p.m., revealed the trained medication employee(TME) administered Client #2's medication. During this time, a one to one staff was not with the client. [See W381] Interview with the registered nurse and the QIDP on September 15, 2011, at approximately 6:30 p.m., revealed that Client #2 is required to have a one to one staff within arms length during "waking" hours. Review of Client #2's BSP dated July 18, 2011, on September 16, 2011, at approximately 9:30 a.m., confirmed Client #2's one to one support begins at 6:30 a.m., and ends at 11:00 p.m. Further review revealed staff is required to be within arms length of the client. At the time of the survey, there was no evidence that Client #2 received consistent one to one support during his waking hours as required by his BSP.	W 189	See Response to W 189 on page 14 of 21.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 331		

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W 331 W 365	<p>Continued From page 17 until they are resolved.]</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW</p> <p>An individual medication administration record must be maintained for each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain medication administration records (MAR) for two of the four clients residing in the facility. (Clients #2 and #3)</p> <p>The findings include:</p> <p>The facility's trained medication employee (TME) failed to document administration of each client's medication in the MAR as evidenced below:</p> <ol style="list-style-type: none"> 1. Observation of the medication pass on September 15, 2011, at 6:00 p.m., revealed that the TME administered Client #2's Cogentin, Zyprexa, Valproic Acid, Generlac and Desmopressin nasal spray. Review of the MAR on the same day, at approximately 6:45 p.m., failed to reflect that the aforementioned medications were administered. 2. Observation of the medication pass on September 15, 2011, at 6:06 p.m., revealed that the TME administered Client #3's Calcium. Review of the MAR on the same day, at approximately 6:45 p.m., failed to reflect that the aforementioned medication was administered. <p>In an interview on September 15, 2011, at approximately 6:45 p.m., the TME acknowledged that he failed to document the administration of</p>	W 331 W 365	<p>W 365</p> <p>1-2 All TMEs will receive additional training on medication administration and appropriate documentation. The DRN will conduct weekly reviews of the MAR and indicate review by signing the back of the MAR. Additionally, random observation of TME medication passes will be conducted.</p>	<p>10/20/2011 -Ongoing</p>

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W 331	Continued From page 15 failed to ensure nursing services were provided in accordance with the needs of one of two clients in the sample (Client #2). The findings include: 1. The facility's nursing services failed to address Client #2's shoulder bruises, as evidenced below: [Cross refer to W153.B1]. On September 15, 2011, at 3:40 p.m., the review of an unusual incident dated October 6, 2010 (8:45 p.m.), revealed staff discovered Client #2 had bruises on each side of his shoulders. On September 15, 2011, at 4:49 p.m., interview with the (designated registered nurse) DRN revealed that staff reported the client's shoulder bruises to her on October 6, 2010, via telephone (9:00 p.m.). Further discussion with the DRN indicated that the medication nurse comes to the facility each morning to administer the clients' medications and to provide immediate nursing interventions, as necessary. The DRN also indicated that the medication nurse should document assessments and treatments provided. On September 15, 2011, at 4:53 p.m., the DRN was requested to provide information concerning nursing interventions to address Client #2's shoulder bruises. Further discussion with the DRN on September 16, 2011, at 4:15 p.m., revealed no nursing records were available for the client's shoulder bruises. Record review on September 16, 2011, at 4:17 p.m., also confirmed no documentation was available to describe assessment, monitoring, or	W 331	W 331 1 - 2. The DRN has received additional training on proper documentation and follow up of reports of changes in status. Additionally, the nurse has been instructed to obtain photographic evidence as applicable and to assess and monitor until resolved. The nurse will review staff log notes on a daily basis to be aware of any changes in individuals' status. Cross Reference Response to W149.	9/23/2011- Ongoing

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W 331	<p>Continued From page 16</p> <p>treatment of Client #2's shoulder bruises. At the time of the survey, there was no evidence that Client #2's shoulder bruises were assessed and monitored by the nurse.</p> <p>2. The facility's nursing services failed to address Client #2's black eye of unknown origin, as evidenced below:</p> <p>On September 15, 2011, at 3:53 p.m., review of an unusual incident dated February 13, 2011 (3:00 a.m.), revealed staff discovered Client #2 had a black eye (under his left eye) and applied first aid. According to the incident report, the residential director (RD) was notified on February 13, 2011, at 7:45 a.m., the qualified intellectual disabilities professional (QIDP) was notified on February 13, 2011 (time unspecified), and the DRN were notified on February 14, 2011 (time unspecified).</p> <p>On September 15, 2011, at 4:17 p.m., interview with the DRN revealed that she was informed of the aforementioned incident and would provide information concerning nursing interventions to address Client #2's left black eye. Further discussion with the DRN and the record review on September 16, 2011, at 4:15 p.m., revealed no nursing records were available for the client's left black eye. At the time of the survey, there was no evidence that the status of Client #2's left eye were assessed and monitored by the nurse.</p> <p>[Note: Interview with the director of nursing (DON) on September 16, 2011, at 4:22 p.m., revealed that changes in a client's health condition, including alterations in skin integrity and bruises, should be monitored by the nurse</p>	W 331	See response to W 331 on page 16 of 21.
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W 365	Continued From page 18	W 365		
W 381	483.460(1)(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 and interview, the facility failed to store drugs under proper conditions of security, for four of four clients residing in the facility. (Client #1, #2, #3 and #4) The finding includes: On September 15, 2011, beginning at 6:00 p.m., the trained medication employee (TME) was observed to leave the door of the medication storage cabinet (located in the kitchen) unlocked, as he walked to the other side of the room. During this time, the TME's back was facing the medication cabinet, as he prepared Client #3's medications for administration. At 6:02 p.m., the TME left the client's medication on the table while he walked away to retrieve the client's water. On September 15, 2011, at 6:06 a.m., the TME administered Client #2's medications, then left the client's medications on the table in the kitchen as he assisted him into the living room. During the aforementioned medication administration, the clients, the direct care staff, and surveyors were observed in the area while the medications were unsecured. After the medication administration, the TME was informed and acknowledged that the medications were	W 381	W 381 Staff trained in medication administration will receive additional instruction in maintaining the security of medications. Staff are required to ensure that the medication cabinets are locked when medications are not being prepared and never to leave medication unattended. All TMEs will receive additional training on safe storage of medication and securing medication during medication pass. The delegating RN and QIDP will randomly monitor medication passes to ensure TME adherence to medication administration procedures (i.e., medications remain secure at all times, not left unattended...) Follow up/corrective action as appropriate will occur in the event of employees' failure to comply with established protocols for securing medications.	10/20/2011 -Ongoing

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W 381	Continued From page 19 unsecured during the medication administration.	W 381		
W 455	483.470(i)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure proper infection control procedures were implemented, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: Observation on September 15, 2011, beginning at 4:15 p.m., revealed the direct support staff sitting in the living room and kitchen engaging the clients with card games and ball games. At 4:28 p.m., Client #2 used his finger to stir his ice tea. The one to one staff then handed the client a paper towel to wipe his hand. At 6:30 p.m., Client #1, #3 and #4 were escorted by staff to the dining room and observed eating their dinner without washing or sanitizing their hands. At 7:03 p.m., Client #2 was observed eating his dinner without washing or sanitizing his hand. Review of the training records on September 15, 2011, at approximately 2:30 p.m., revealed that staff was trained on infection control on April 5, 2011 to include hand washing. Interview with the qualified intellectual disabilities professional (QIDP) professional and the registered nurse on September 16, 2011, at	W 455	W 455 Training on infection control will be done by the DRN (included but not limited to proper hand washing techniques). Additionally the infection control training will highlight the importance of supporting Client 's #1. #2. #2 and #4 with washing their hands prior to meals. Periodic observation and reinforcement will be given as necessary.	10/20/2011 -Ongoing

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W 455	Continued From page 20 approximately 3:30 p.m., revealed all clients are required to wash their hands before eating. There was no evidence that proper infection control procedures were implemented.	W 455	See response to W 455 on page 20 of 21.	

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I 000 INITIAL COMMENTS

A licensure survey was conducted from September 15, 2011 through September 16, 2011. A sampling of two residents was selected from a residential population of four males with various intellectual disabilities.

The findings of the survey were based on observations and interviews with staff in the home and at one day programs, as well as a review of resident and administrative records, including incident and investigation reports.

[Qualified mental retardation professional(QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

I 090 3504.1 HOUSEKEEPING

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.

This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of four of four residents in the facility (Residents #1, #2, #3 and #4)

The findings include:

A. On September 16, 2011, beginning at 3:15 p.m., the qualified intellectual disabilities professional (QIDP) accompanied the surveyor

I 000

I 090

See response to I090 on page 2 of 14.

Health Regulation & Licensing Administration

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

[Handwritten Signature]

TITLE

(X6) DATE

10/27/11

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2011	
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019		
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1090	<p>Continued From page 1</p> <p>during observations of the environment. The following concerns were identified:</p> <ol style="list-style-type: none"> 1. A hole, approximately two inches in diameter, was observed in the wall of Resident #2 and #3's bedroom. 2. The outer glass on the oven door was broken. On September 16, 2011, at approximately 3:35 p.m., interview with the QIDP and further observation, revealed another oven was available for baking foods. Further discussion with the QIDP revealed that the replacement glass for the oven door had been ordered. 3. A kitchen cabinet door was broken off the hinge. 4. Broken pieces of a heavy duty cardboard were observed covering a small area in the backyard. Further observation revealed the cardboard covered an area of the yard that was slightly lower than the surrounding area. <p>During the environmental observations, the QIDP acknowledged the aforementioned findings.</p>	1090	<p>1090</p> <ol style="list-style-type: none"> 1. The hole in the wall of resident # 2 and #3's bedroom has been repaired. 2. The oven glass door was being repaired 10/18/2011 by professional installers who accidentally broke the new glass upon installation. The glass has been reordered and will be reinstalled by 11/10/2011. 3. The cabinet door in the kitchen has been placed back on its hinge in the kitchen. 4. The QIDP/Program Manager will have repaired/ the indentation in the backyard that was covered by cardboard. <p>On an ongoing basis, the QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repairing as necessary</p>	<p>10/15/2011</p> <p>10/18/2011</p> <p>10/5/2011</p> <p>10/31/2011</p> <p>9/19/2011-Ongoing</p>
1180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for one of the two residents in the sample. (Resident</p>	1180	<p>Response to 1180 on page 3 of 14.</p>	

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I 180	<p>Continued From page 2</p> <p>#2)</p> <p>The findings include:</p> <p>1. [Cross refer to I420]. The facility's qualified intellectual disabilities professional (QIDP) failed to ensure Resident #2 received continuous active treatment.</p> <p>2. The QIDP failed to ensure the primary care physician (PCP) was notified of a new medication prescribed by the neurologist for Resident #2.</p> <p>Observation of the medication administration on September 15, 2011, at 6:06 p.m., revealed the trained medication employee (TME) administered Cogentin to Resident #2. Moments later, review of Resident #2's medication administration records (MARS), revealed that the resident began the aforementioned medication on September 7, 2011. Continued review revealed the neurologist wrote a prescription for Cogentin on August 25, 2011, however the medical record revealed no evidence that the primary care physician (PCP) had counter-signed the neurologist prescription.</p> <p>Interview with the registered nurse (RN) on September 19, 2011, at approximately 11:30 a.m., revealed that the PCP had agreed with the prescription, however failed to write or order the prescribed medication for Resident #2.</p> <p>The facility failed to evidence that the PCP was made aware of the aforementioned medication prescribed by the neurologist.</p>	I 180	<p>I180</p> <p>1. Unable to provide a corrective action response as deficiency cross reference a citation that was not included in the statement of deficiencies (W420)</p> <p>2. The PCP was made aware of prescription by the neurologist for Client #2 via phone and gave his approval. Consult sheet has been signed by the PCP. In the future, the DRN will document telephone approval by PCP prior to obtaining signature on the consult sheet. The delegating RN, will provide additional training to LPN and TME in correct medication administration procedures including notification of new medication to delegating RN and PCP. Delegating RN will review all medical consult documentation upon completion of medical appointments to ensure notification of all medication changes. In the event that the procedures are not followed, corrective action as appropriate will ensue.</p> <p>10/15/2011 -Ongoing</p>
I 189	3508.7 ADMINISTRATIVE SUPPORT	I 189	<p>Each GHMRP shall maintain records of residents funds received and disbursed.</p>

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I 189	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual Disabilities (GHPID) failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for one of two residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and review of Resident #1's financial records on September 16, 2011, at 2:45 p.m., revealed that the facility assisted the resident with maintaining his finances. Continued interview and record review revealed that the resident received Supplemental Security Income (SSI) monthly.</p> <p>Review of Resident #1's bank statements on September 16, 2011, beginning at 2:45 p.m., revealed a withdrawal of \$100.00 on August 25, 2011, and another withdrawal of \$100.00 on September 20, 2010. Additional review revealed no receipts to show how the money was spent. Interview with the QIDP on September 16, 2011, at 3:00 p.m., revealed that she would retrieve the receipts from the financial department; however, at the time of the survey, the receipts were not presented for review.</p>	I 189	<p>I189</p> <p>The outstanding bank receipts for Client #1 have been secured and placed on file in their financial record book in the administrative office. Review of the records indicated that the receipts for the \$100.00 August 25, 2010 (reflected as 2011 in the deficiency report) withdrawal and \$100.00 for September 20, 2010 were retrieved from the financial records that were being audited in the financial office and faxed to DOH on 9/18/2011. QIDP/Program Manager will complete monthly reconciliation of all individual finances to ensure that client receipts are timely placed in their financial record books. Director of Programs and Accounts Receivables Specialist will perform monthly monitoring to ensure compliance. In cases when the Program Manager does not maintain the financial record in accordance with agency procedure, corrective action as appropriate will ensue.</p>	9/19/2011-Ongoing
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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</p>	I 206		

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I 206	<p>Continued From page 4 duties.</p> <p>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 an annual health certificate was available for three of six consultants. (C1, C2, and C3) and for five of eleven facility staff (direct support staff #2, #3, #4, #5 and #6).</p> <p>The findings include:</p> <p>On September 15, 2011, at approximately 9:20 a.m., the facility's qualified intellectual disabilities professional (QIDP) was requested to provide current health certificates for all staff, consultants, and other professionals providing services to the residents at the home. The QIDP indicated that she would obtain the requested records from the administrative office for review.</p> <p>On September 16, 2011, at 8:45 a.m., the review of the available health certificates determined that they were expired for staff S1, S2, S3, S4, and S5. Additionally, the record review revealed that the health certificates of consultants C1, C2, and C3 were also expired.</p> <p>Further discussion with the QIDP on September 16, 2011, at 3:45 p.m. confirmed that current health certificates were not available for the aforementioned staff and consultants.</p>	I 206	<p>I206 The outstanding health certificates for the and staff #1-5 and consultants #1-3 have been secured and placed on file in their health records in the administrative office.</p> <p>QIDP/Personnel Administrator will ensure that all employees and health care professional have current health Personnel Administrator will perform quarterly monitoring to ensure compliance and adequate notification to employees of upcoming expiration dates. Employees who are not compliance with having their health certifications completed annually per protocols and regulations will be removed from the schedule until such time that their health certifications have been completed/received by Human Resources.</p> <p>10/3/2011-Ongoing</p>
I 227	3510.5(d) STAFF TRAINING	I 227	Each training program shall include, but not be

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1227	<p>Continued From page 5</p> <p>limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHIPD) failed to ensure five of ten staff working in the facility had current training to implement emergency measures. (direct support staff #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2011, at 9:25 a.m., the qualified intellectual disabilities professional (QIDP) was requested to obtain the training records for the staff.</p> <p>Record review on September 16, 2011, beginning at 8:45 a.m., revealed the GHPID failed to provide evidence that five direct support staff had a current certification on Cardiopulmonary Resuscitation (CPR). Further record review revealed no current First Aide certification was available for S5.</p> <p>Interview with the QIDP on September 16, 2011, at approximately 9:45 a.m. revealed that she would telephone the administrative office to determine if CPR and First Aide certifications were available for the aforementioned staff. On the same day at 3:45 p.m., the QIDP confirmed that current CPR and First Aide certifications had not been provided for the identified staff for review.</p>	1227	<p>I227</p> <p>The CPR Certifications for all direct support staff have been placed on file in their training records. Sign in sheet indicating their participation in and successful completion of the training has been placed on file in their training records.</p> <p>Professional Development Coordinator/Director of Programs will perform quarterly training record audits of all employee training records to ensure compliance. Notification to employees of expiring certifications will be issued 60 days prior to expiration along with a schedule of upcoming classes in which the employees will be registered. Employees who fail to renew their CPR certifications prior to their expiration will be removed from the schedule until such time that their CPR certifications are current and received by the training department</p>
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I 379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of 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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with individual disabilities (GHPID) failed to ensure unusual incidents that interfered substantially with the resident's health was reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), for two or two residents in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>A. On September 15, 2011, at 9:25 a.m., interview with the residential director (RD) revealed that the following usual incidents had occurred:</p> <p>1. On September 15, 2010 (10:00 a.m.), Upon checking Resident #1, an overnight staff discovered that he had "a black eye with a goose egg knot over his eye brow area", which was determined to be of unknown origin.</p> <p>Interview with the RD and the qualified intellectual disabilities professional (QIDP) on September 15, 2011, at 10:30 a.m., revealed that the</p>	I 379	See response to I379 on page 8 of 14.

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I 379	<p>Continued From page 7</p> <p>Department of Health (DOH) should have been informed of Resident #1's injury. The review of the incident report on September 15, 2011, at 9:42 a.m., and of the corresponding investigative report dated September 21, 2010, on September 16, 2011, at 12:17 p.m., however, failed to evidence that the resident's injury had been reported.</p> <p>2. Further discussion with the RD on September 15, 2011, at 9:40 a.m., revealed that on November 16, 2010 at 2:40 p.m., Resident #2 was allegedly verbally abused by his residential 1:1 staff, while he was at his day program. According to the RD, the incident that occurred at the day program should be reported by the day program.</p> <p>Interview with the QIDP on September 15, 2011, at 10:47 a.m., revealed that she would follow-up with the administrative office to determine if the incident was reported to DOH. Interview with the QIDP on September 16, 2011, at 10:40 a.m., confirmed that the incident had not been reported to the DOH.</p> <p>On September 16, 2011, at 10:42 a.m., review of the verbal notification for the incident confirmed that the aforementioned allegation of verbal abuse of Resident #2 had not been reported to the DOH.</p> <p>B. On September 15, 2011, at 3:40 p.m., and 3:53 p.m. respectively, review of unusual incidents revealed that Resident #2 sustained two injuries of unknown origin, as evidenced below:</p> <p>1. October 6, 2010 (8:45 p.m.): While dressing Resident #2 for his p.m. care, the resident's 1:1 staff discovered a bruise on each side of his</p>	I 379	<p>I379</p> <p>A. 1-2, & B1-2. Provider IMC will retrain all staff on the incident management reporting policies and procedures and policies incident management to ensure that staff are aware of the policies that govern incident management both internally and externally (with an emphasis on timely and required notification). In addition to routine on site observation, the Program Manager, QIDP and DRN will monitor the documentation for unusual incidents to ensure that all incidents are managed in accordance with established policies and procedures. In the event that policies for incident management, corrective action as appropriate will ensue.</p>	10/20/2011 -Ongoing

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I 379	Continued From page 8 shoulders. Further record review, however, revealed the UIR did not include a description of the size of the resident's bruises. Continued review of the incident report failed to provide evidence that the DOH had been notified of the incident. Interview with the QIDP on September 15, 2011, at 4:45 p.m., and on September 16, 2011 at 1040 a.m., confirmed that the incident had been not been reported to the DOH. 2. February 13, 2011 (3:00 a.m.): Staff reported that Resident #2 was discovered with a black eye (left lower eye), while assisting him from the living room to his bedroom. On September 15, 2011, at 3:45 p.m., continued review of the incident report failed to provide evidence that the DOH had been notified of the incident. Interview with the QIDP on September 16, 2011, at 1040 a.m., confirmed that the incident had been not been reported to the DOH. [Note: Post survey review of reported unusual incidents on September 19, 2011 revealed that the aforementioned incidents had not been reported.]	I 379	See response to I379 on page 8 of 14		
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:	I 401	See response to I401 on pages 10 and 11 of 14.		

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I 401	<p>Continued From page 9</p> <p>Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that 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 four of four residents in the sample. (Residents #1, #2, #3, and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure nursing services in accordance with the needs of Resident #2. <ol style="list-style-type: none"> a. The facility's nursing services failed to address Resident #2's shoulder bruises of unknown origin, as evidenced below: On September 15, 2011, at 3:40 p.m., the review of an unusual incident dated October 6, 2010 (8:45 p.m.), revealed staff discovered Resident #2 had bruises on each side of his shoulders. On September 15, 2011, at 4:49 p.m., interview with the (designated registered nurse) DRN revealed that staff reported the resident's shoulder bruises to her on October 6, 2010, via telephone (9:00 p.m.). Further discussion with the DRN indicated that the medication nurse comes to the facility each morning to administer the residents' medications and to provide immediate nursing interventions, as necessary. The DRN also indicated that the medication nurse should document assessments and treatments provided. On September 15, 2011, at 4:53 p.m., the DRN was requested to provide information concerning nursing interventions to address Resident #2's 	I 401	<p>I401</p> <p>1a-b. The DRN has received additional training on proper documentation and follow up of reports of changes in status. Additionally, the nurse has been instructed to obtain photographic evidence as applicable and to assess and monitor until resolved. The nurse will review staff log notes on a daily basis to be aware of any changes in individual's status in a timely manner.</p> <p>2. All TMEs will receive additional training on medication administration and appropriate documentation. The DRN will conduct weekly reviews of the MAR and document on the back of the MAR. Additionally, random observation of TME medication passes will be conducted.</p>	<p>9/23/2011- Ongoing</p> <p>10/20/2011 -Ongoing</p>

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I 401	<p>Continued From page 10</p> <p>shoulder bruises. Further discussion with the DRN on September 16, 2011, at 4:15 p.m., revealed no nursing records were available for the resident's shoulder bruises.</p> <p>Record review on September 16, 2011, at 4:17 p.m., also confirmed no documentation was available to describe assessment, monitoring, or treatment of Resident #2's shoulder bruises. At the time of the survey, there was no evidence that Resident #2's shoulder bruises were assessed and monitored by the nurse.</p> <p>b. The facility's nursing services failed to address Resident #2's black eye of unknown origin, as evidenced below:</p> <p>On September 15, 2011, at 3:53 p.m., review of an unusual incident dated February 13, 2011 (3:00 a.m.), revealed staff discovered Resident #2 had a black eye (under his left eye) and applied first aid. According to the incident report, the residential director (RD) was notified on February 13, 2011, at 7:45 a.m., the qualified intellectual disabilities professional (QIDP) was notified on February 13, 2011 (time unspecified), and the DRN were notified on February 14, 2011 (time unspecified).</p> <p>On September 15, 2011, at 4:17 p.m., interview with the DRN revealed that she was informed of the aforementioned incident and would provide information concerning nursing interventions to address Resident #2's left black eye. Further discussion with the DRN and the record review on September 16, 2011, at 4:15 p.m., revealed no nursing records were available for the resident's left black eye. At the time of the survey, there was no evidence that the status of Resident #2's left eye were assessed and</p>	I 401	<p>I401 continued</p> <p>Staff trained in medication administration will receive additional instruction in maintaining the security of medications. Staff are required to ensure that the medication cabinets are locked when medications are not being prepared and never to leave medication unattended.</p> <p>The delegating RN and QIDP will randomly monitor medication passes to ensure TME adherence to medication administration procedures (i.e, medications remain secure at all times, not left unattended...).</p> <p>Follow up/corrective action as appropriate will occur in the event of employees' failure to comply with established protocols for securing medications.</p>	10/20/2011 -Ongoing

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I 401	Continued From page 11 monitored by the nurse. [Note: Interview with the director of nursing (DON) on September 16, 2011, at 4:22 p.m., revealed that changes in a resident's health condition, including alterations in skin integrity and bruises, should be monitored by the nurse until they are resolved.] 2. [See federal deficiency report - Citation W365]. The facility failed to ensure medication administration records (MAR) were accurately maintained for Residents #2 and #3) 3. [See federal deficiency report - Citation W381]. The facility failed to ensure drugs were stored under proper conditions of security for Residents #1, #2, #3, and #4.	I 401	See response to I401 on pages 10 and 11 of 14.
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 intellectual 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 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for two of two residents in the sample. (Residents #1 #2).	I 500	See response to I500 on page 13 and 14 of 14.

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2011
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019
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(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
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I 500	<p>Continued From page 12</p> <p>(§ 7-1306.10. Mistreatment, neglect or abuse prohibited; use of restraints; seclusion; "time-out" procedures [Formerly § 6-1970]</p> <p>(e) Alleged instances of mistreatment, neglect or abuse of any customer shall be reported immediately to the Director, and the Director shall inform the customer's counsel, parent or guardian who petitioned for the commitment, and the customer's mental retardation advocate of any such instances. There shall be a written report that the allegation has been thoroughly and promptly investigated (with the findings stated therein). Employees of facilities who report such instances of mistreatment, neglect, or abuse shall not be subjected to adverse action by the facility because of the report.)</p> <p>The findings include:</p> <p>The GHPID failed to investigate injuries of unknown origin for Resident #2.</p> <p>a. [Cross refer to W153.B1] On September 15, 2011, at 3:40 p.m., review of an unusual incident dated October 6, 2010, at 8:45 p.m., revealed the 1:1 staff discovered Resident #2 had bruises on each side of his shoulders. Documentation of verbal notifications revealed that on the same day at 8:50 p.m., and 9:00 p.m. respectively, the RD and the designated registered nurse (DRN) were notified.</p> <p>Interview with the QIDP on September 15, 2011, at 4:45 p.m., revealed she would obtain the investigation report for Resident #2's bruises on his shoulders. On September 16, 2011, at 10:40 a.m., further discussion with the QIDP, and the</p>	I 500	<p>1500</p> <p>a-b. Review of records indicate that Client #1's eye was noted by staff as being swollen at 12am however, was not noted as being black until he awoke the following morning.</p> <p>IMC will retrain all staff on the incident management reporting policies and procedures and policies incident management to ensure that staff are aware of the policies that govern incident management both internally and externally (with an emphasis on timely and required notification).</p> <p>Further investigation into the incident that occurred on February 13, 2011 for client #2 was not reported to the IMC, although the record indicated that notification was made to the Director and IMC. The Incident report was reportedly faxed to the main office, since the time of this incident a designated fax line has been established to streamline the receipt of incident reports during both business and non-business hours.</p>	10/20/2011 -Ongoing
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FORM APPROVED

Health Regulation & Licensing Administration		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2011
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0228	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(X4) IC PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	
I 500	Continued From page 13 <p>review of available records revealed no investigation report for the incident.</p> <p>At the time of the survey, there was no evidence the facility conducted an investigation of Resident #2's shoulder bruises of unknown origin.</p> <p>b. [Cross refer to W153.B2]. On September 15, 2011, at 3:53 p.m., review of an unusual incident dated February 13, 2011 (3:00 a.m.), revealed staff discovered Resident #2 had a black eye (under his left eye), as he was assisted to his room.</p> <p>Review of the unusual incident report on September 15, 2011, at 3:55 p.m., revealed on February 13, 2011, at 7:45 a.m., the residential director was notified. Further review of the unusual incident revealed the QIDP and the DRN were notified on February 13, 2011, and February 14, 2011, respectively, however the record failed to document a time of day for the notifications.</p> <p>Interview with the QIDP on September 15, 2011, at 4:45 p.m., revealed the administrative office would be contacted to obtain the investigation report for Resident #2's black eye; however, the facility failed to provide evidence that Resident #2's black eye was investigated.</p> <p>At the time of the survey, they was no evidence the facility had conducted an investigation of Resident #2's black eye of unknown origin.</p>	I 500	10/20/2011 -Ongoing