

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

PRINTED: 05/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G116</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MY OWN PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>121 TUCKERMAN ST, NE WASHINGTON, DC 20011</b>	
(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
W 000	INITIAL COMMENTS  Surveyor: 27828 A recertification survey was conducted from May 7, 2012 through May 8, 2012. A sample of two clients was selected from a population of four men with various degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.  The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, administrative staff and two client, as well as a review of client and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	<b>6/20/12</b> <b>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</b>	
W 140	483.420(b)(1)(i) CLIENT FINANCES  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.  This STANDARD is not met as evidenced by: Surveyor: 27828 Based on staff interview and record review, the facility failed to provide a complete accounting of clients' personal funds, for one of the two clients in the sample. (Client #1)  The finding includes:  Interview with the qualified intellectual disabilities professional (QIDP) on May 7, 2012, at 3:18 p.m.,	W 140	W140  Client #1's personal funds are maintained in a sub account under the facility due to a lack of identification.  The Program Manager has received re-training on the protocol for securing funds from client#1's account which includes submitting a Disbursement Voucher identifying the purpose for the funds being requested. The Disbursement Voucher is then routed to the Director of Programs for review and approval and then forwarded to the accounting department to release the funds and allocate the disbursement accordingly  The Accounting Specialist in conjunction with Account Receivables personnel will ensure that all authorized disbursements as well as any deposits are reconciled on monthly basis and provide at a minimum a quarterly statement with account activity and reconciliation verification.  Director of Programs and Quality and QIDP, in conjunction with My Own Place, Inc.'s accounting department will monitor Client #1's banking documentation routinely to ensure adherence to the agency protocol and efficient record keeping practices.	5/15/12- Ongoing

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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W 140	Continued From page 1 revealed that the facility assisted the client with maintaining his finances. Review of Client #1's financial records however, revealed no bank statements were available for review.  Interview with the QIDP on May 7, 2012 at 3:20 p.m., revealed that Client #1 did not have identification to open an account at the bank. Therefore, the client's bank account was opened in the facility's name. Continued interview revealed she was not able to produce all of the client's financial information because the financial officer was on vacation.  At the time of the survey, the facility failed to provide a complete accounting of Client #1's personal funds.	W 140	W140 Response to W140 on page 1 of 11
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.  This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, interview and record review, the facility failed to ensure staff were provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of two clients in the sample. (Client #1)  The finding includes:  Observation on May 7, 2012, at 7:00 p.m., revealed Client #3 dropped his Depakote	W 189	W189 Response to W189 on page 3 of 11

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W 189	<p>Continued From page 2</p> <p>medication on the floor. Further observation revealed the trained medication employee (TME) placed the medication back in the medication cabinet.</p> <p>Interview with the TME at approximately 8:20 p.m., revealed she did not know how to dispose of the medication. At approximately 8:40 p.m., the TME flushed the Depakote in the toilet. When asked, the TME stated that the registered nurse (RN) told her to flush the medication.</p> <p>On May 8, 2012, at approximately 9:45 a.m., review of the facility's policy, titled "disposal of unused medication" revealed, "when a medication needs to be disposed of because it has been dropped on the floor during administration, the unused medication will be turned over to the registered nurse. The nurse will either return the medication to the area pharmacist or destroy the medication."</p> <p>Interview with the RN coordinator on May 8, 2012, at approximately 9:50 a.m., revealed that a drug that has fallen on the floor is to be thrown in the trash, and a controlled drug is destroyed in front of two witnesses.</p> <p>Review of the training book on May 8, 2012, at approximately 10:00 a.m., failed to reveal training on medication disposal. However, interview with the RN at approximately 9:50 a.m., revealed all TME's were trained on disposal of unused medication.</p> <p>At the time of the survey, there was no documented evidenced that staff had been trained on the disposal of unused medication.</p>	W 189	<p>W189</p> <p>Director of Nursing will provide the RN with additional training on the disposal of medication. The RN will subsequently train all TMEs on medication policies and procedures including medication disposal by 6/5/12. To ensure accurate administration of medication to all clients, the facility RN will continue to observe all TMEs,. In addition, facility RN will conduct periodic spot checks during medication pass to ensure compliance. Corrective action as needed will occur for any issues noted during the periodic medication observations. Documentation of these actions as well as the observations will be maintained on file in the employee's inservice record.</p>	6/5/12- Ongoing

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W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observations, interviews and the review of records, the facility failed to ensure that each client's individual program plan stated specific objectives necessary to meet each client's needs, as identified by the comprehensive assessment, for one of two clients in the sample. (Clients #2)  The finding includes:  Observation on May 8, 2012, at 6:17 p.m., revealed Client #2 was administered his medications by the facility's trained medication employee (TME). The TME was observed to punch the client's medications from the bubble packs into a cup and hand it to the client. The client then swallowed his medications and drank prune juice.  On May 8, 2012, at 12:08 p.m., review of Client #2's self-medication assessment dated February 15, 2011, revealed the client "is able to independently get his cup of water, punch out medication from bubble pack, take his medications and return cup to the sink. He however needs someone to assist in the process because he cannot identify his medications and does not know the reason they are given." It should be noted that the surveyor was able to	W 227	W227  Client #2 self medication objectives will be re-assessed by facility RN by 6/1/12. If necessary, objectives will be revised to meet his specific needs. The RN will review self medication objectives for each individual annually and incorporate individualized goals to meet each clients needs. In addition, facility RN will conduct periodic reviews of self medication data sheets to ensure compliance as well as identify any modifications that may be needed to ensure the goal is functional based upon identified abilities and support needs.	6/1/12- Ongoing	

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**W 227** Continued From page 4  
converse with the client and observed the client talking to his peers and his staff throughout the morning and the evening.

Interview with the facility's registered nurse (RN) on May 8, 2012, at approximately 9:30 a.m. revealed that she was aware of the aforementioned training need for Client #2 and further indicated that area of need would be addressed in the client's upcoming individual support plan meeting in May 2012. At the time of the survey, however, the facility failed to provide evidence that an objective necessary to address Client #2's self-medication program need had been developed.

**W 227**

**W227**

See response to W227 on page 4 of 11

**W 368** 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:  
Surveyor: 27828  
Based on observation, record review and interview, the facility failed to ensure that all prescribed medications were administered in accordance with each client's physician orders, for two of the four clients residing in the facility. (Clients #1 and #3)

The findings include:

Observation of the medication administration on May 7, 2012, at 6:52 p.m., revealed the trained medication employee (TME) punched Client #3's medication from his blister pack and handed the cup of medications to the client. As the client was

**W 368**

**W368**

Reference Response to W189 on page 3 of 11.

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W 368 Continued From page 5  
taking his medications, a pill (Depakote) fell on the floor. The TME then said she was going to inform the registered nurse coordinator (RNC). However, the TME failed to call the RNC after she completed her medication administration at 7:25 p.m. At 7:30 p.m., review of the client's medication administration record (MAR) and physician orders dated April 1, 2012, revealed an order for Depakote. Continued review of the MAR revealed the aforementioned medication was prescribed for 6:00 p.m.

Further observation at 8:12 p.m., revealed the TME was cleaning the kitchen. When asked, the TME stated that she will call the RNC before the end of her shift at 11:00 p.m. At approximately 8:40 p.m., the TME called the RNC. The TME then stated that the RNC instructed her to administer the medication. Observation at 8:43 p.m., revealed the TME administered Client #3's Depakote.

At the time of the survey, the facility failed to ensure Client #3 was administered his Depakote timely.

W 369 483.460(k)(2) DRUG ADMINISTRATION  
The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  
  
This STANDARD is not met as evidenced by:  
Surveyor: 27828  
Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for two of the four clients residing in the facility.

W 368

W368

Reference Response to W189 on page 3 of 11.

6/5/12-  
Ongoing

W369

See Response to W189 on page 3 of 11.

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W 369	Continued From page 6 (Clients #1 and #3)  The findings include:  Observation of the medication administration on May 7, 2012, at 6:52 p.m., revealed the trained medication employee (TME) punch Client #3's medication from his blister pack and handed the cup of medications to the client. As the client was taking his medications, a pill (Depakote) fell on the floor. The TME then said she was going to inform the registered nurse coordinator (RNC). However, the TME failed to call the RNC after she completed her medication administration at 7:25 p.m. At 7:30 p.m., review of the client's medication administration record (MAR) and physician orders dated April 1, 2012, revealed an order for Depakote. Continued review of the MAR revealed the aforementioned medication was prescribed for 6:00 p.m.  Further observation at 8:12 p.m., revealed the TME was cleaning the kitchen. When asked, the TME stated that she will call the RNC before the end of her shift at 11:00 p.m. At approximately 8:40 p.m., the TME called the RNC. The TME then stated that the RNC instructed her to administer the medication. Observation at 8:43 p.m., revealed the TME administered Client #3's Depakote.  At the time of the survey, the facility failed to ensure Client #3 was administered his Depakote timely.	W 369	W369  The RN will train all TMEs on medication policies and procedures including timely medication administration and medication errors by 6/5/12. To ensure accurate administration of medication to all clients, the facility RN will continue to observe all TMEs. In addition, facility RN will conduct periodic spot checks during medication pass to ensure compliance.	6/5/12- Ongoing
W 370	483.460(k)(3) DRUG ADMINISTRATION  The system for drug administration must assure that unlicensed personnel are allowed to	W 370		

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W 370	<p>Continued From page 7 administer drugs only if State law permits.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, staff interview and record verification, the facility failed to ensure that unlicensed personnel were not permitted to administer drugs for one of the four clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>Observation of the medication administration on May 7, 2012, at 6:40 p.m., revealed Client #1 was administered Vitron C, Docusate, Calcium, and Nexium. At 7:54 p.m., review of the client's medication administration record (MAR) and physician orders dated April 1, 2012, revealed an order for Debrox (twice a day). Continued review revealed the TME initialed the MAR for 6:00 p.m., indicating the medication was given. However, it was not administered during the evening medication pass.</p> <p>Interview with the TME at 8:20 p.m., revealed "whoever gives him a shower will give it". The surveyor then asked Staff #2, who had given Client #1 his shower at approximately 7:30 p.m., if she had administered the client's Debrox. Staff #2 stated that she did not administer the Debrox. The TME then opened the medication cabinet and handed the Debrox to Staff #2. At 8:23 p.m., Staff #2 assisted Client #1 into the bathroom and administered Debrox in the right and left ear.</p> <p>Further interview at 8:25 p.m., on the same day with the qualified intellectual disabilities</p>	W 370	<p>W370</p> <p>Staff #2 was cautioned on 5/19/12 that she is not permitted to administer medication in the District of Columbia until her TME application process is completed. Additionally, all TMEs will be reminded that they may only administer medications in the jurisdiction of their certification. The RN will review MARs periodically to monitor compliance and implement corrective action as necessary in the event of non-compliance.</p>	5/19/12-Ongoing
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W 370	Continued From page 8 professional (QIDP) revealed that Staff #2 was not a TME. Interview with Staff #2 revealed that she was a TME in Maryland; however, she is not licensed in the District of Columbia.  Interview with the registered nurse coordinator (RNC) on May 8, 2012, at approximately 9:00 a.m., confirmed that Staff #2 was not a certified TME. Further adding that all drugs are to be administered by licensed nurses, or staff trained and certified in medication administration.	W 370			
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING  The facility must store drugs under proper conditions of security.  This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation and interview, the facility failed to store drugs under proper conditions of security, for four of the four clients residing in the facility. (Clients #1, #2, #3, and #4)  The findings include:  1. On May 7, 2012, beginning at 6:35 p.m., the trained medication employee (TME) was observed to leave Client #2 and #3's Generlac (oral laxative) on top of the medication cabinet in the dining room as she administered medications in the clients' bedrooms. Other clients and staff were in close proximity to the medication.  2. On May 7, 2012, at 6:39 p.m., the TME was observed to walk to the bathroom to wash her	W 381	W381  1 - 4. The RN will train all TMEs on medication policies and procedures including storage and security of medication during the medication pass by 6/5/12. In addition, facility RN will conduct periodic spot checks during medication pass to monitor compliance. Documentation of the outcome of the random medication administration observations will be maintained in the TME's training file along with any corrective action necessary as the result of the observation.	6/5/12- Ongoing	

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W 381	Continued From page 9 hands. During this time Client #2's medications were left unattended in the client's bedroom as the client waited.  3. On May 7, 2012, at 6:53 p.m., the TME was observed to walk to the living room and the dining room to retrieve a medication book and cup. Afterwards, the TME walked to the bathroom to wash her hands. During this time Client #3's medications were left unattended in his bedroom as the client waited.  4. On May 7, 2012, at 8:45 p.m., the TME was observed to walk to the bathroom to wash her hands. During this time Client #3's Depakote was left on the dining room table. Further observation revealed clients and staff were in close proximity to the unattended medication.  Interview with the TME on May 7, 2012, at 8:48 p.m., confirmed the aforementioned medications were left unsecured.  Interview with the registered nurse coordinator on May 8, 2012, at 9:10 a.m., revealed that all medications were required to be secured at all times by a licensed professional.  The TME failed to ensure the security of all drugs during the evening medication administration observations on May 7, 2012.	W 381	W381 See Response to W381 on page 9 of 11.	6/5/12- Ongoing
W 454	483.470(J)(1) INFECTION CONTROL  The facility must provide a sanitary environment to avoid sources and transmission of infections.  This STANDARD is not met as evidenced by:	W 454		

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W 454	<p>Continued From page 10 Surveyor: 27828 Based on observation, interview and record review, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>Observation on May 7, 2012, beginning at 4:50 p.m., revealed Client #1 urinated on himself while sitting on the couch. Continued observation revealed the couch was soiled. Staff #2 then informed the other staff that she was going to change Client #1. At 4:54 p.m., Staff #2 returned to the dining room with Client #1 and began to engage him in a table top activity. During this time Clients and staff were walking in the dining room. At 5:02 p.m., the surveyor informed Staff #2 that the couch was soiled. The staff then stated "I know I'm going to do it." The qualified intellectual disabilities professional (QIDP) overheard the conversation and instructed the staff to disinfect the couch.</p> <p>Review of the training records on May 8, 2012, at approximately 2:30 p.m., revealed that staff was trained on infection control on July 23, 2011.</p> <p>Interview with the registered nurse coordinator on May 8, 2012, at 9:35 a.m., revealed the staff was required to clean the soiled area immediately.</p> <p>There was no evidence that proper infection control procedures were implemented.</p>	W 454	<p>W454</p> <p>To ensure proper infection control procedures, the facility RN will provide in-service training to all staff on Universal Precaution and Infection Control policies and procedures who were not present for the annual refresher training by 6/5/12. Additionally, Universal Precaution and Infection Control refresher training will continue to occur on an annual or as needed basis for all employees. Facility RN, QIDP, and Program Manager will conduct periodic monitoring of the environment to ensure sanitary conditions and proper infection control procedures are implemented.</p>	6/5/12- Ongoing
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MY OWN PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>121 TUCKERMAN ST, NE WASHINGTON, DC 20011</b>	
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 27828 A licensure survey was conducted from May 7, 2012 through May 8, 2012. A sample of two residents was selected from a population of four men with various degrees intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, administrative staff and two clients, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000	
1 189	<p><b>3508.7 ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP shall maintain records of residents' funds received and disbursed.</p> <p>This Statute is not met as evidenced by: Surveyor: 27828 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 Client #1's financial records on May 7, 2012, at 3:18 p.m., revealed there were no bank statements for Client #1.</p>	1 189	<p>1 189</p> <p>Client #1's personal funds are maintained in a sub account under the facility due to a lack of identification.</p> <p>The Program Manager has received re-training on the protocol for securing funds from client#1's account which includes submitting a Disbursement Voucher identifying the purpose for the funds being requested. The Disbursement Voucher is then routed to the Director of Programs for review and approval and then forwarded to the accounting department to release the funds and allocate the disbursement accordingly</p> <p>The Accounting Specialist in conjunction with Account Receivables personnel will ensure that all authorized disbursements as well as any deposits are reconciled on monthly basis and provide at a minimum a quarterly statement with account activity and reconciliation verification.</p> <p>Director of Programs and Quality and QIDP, in conjunction with My Own Place, Inc.'s accounting department will monitor Client #1's banking documentation routinely to ensure adherence to the agency protocol and efficient record keeping practices.</p> <p>5/15/12-ongoing</p>

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TITLE

(X6) DATE

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

STATE FORM

6889

RTTW11

If continuation sheet 1 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2012</b>
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I 189	Continued From page 1  Interview with the QIDP on May 7, 2012 at 3:20 p.m., revealed that Client #1 did not have identification to open an account at the bank. Therefore, the client's bank account was opened in the facility's name. Continued interview revealed she was not able to produce all of the client's financial information because the financial officer was on vacation.  At the time of the survey, the facility failed to provide a complete accounting of Client #1's personal funds.	I 189	I 189  Reference response to I 189 on page 1 of 5.	6/5/12
I 206	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: Surveyor: 27828 Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for one of the eleven consultants. (Consultant #1)  The finding includes:  On May 8, 2012, beginning 3:00 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate	I 206	I 206  Health Certificate for Consultant #1 was secured on 5/9/12 and placed in the file.  M.O.P. Human Resource Department and Director of Health Services will ensure that all staff and consultants secure an annual health screening (physician's certificate) to ensure the health and safety of its individuals. These certificates will be maintained in the staff personnel files for review. In cases when staff that are not in compliance, they will be placed on administrative leave. Additionally, quality assurance monitoring will review a random sample of personnel files quarterly to ensure compliance.	5/9/12- Ongoing

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NAME OF PROVIDER OR SUPPLIER  <b>MY OWN PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>121 TUCKERMAN ST, NE WASHINGTON, DC 20011</b>
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I 206	Continued From page 2  for Consultant #1. At approximately 3:30 p.m., on the same day, interview with the House Manager (HM) confirmed that there was no evidence of health inventories performed by a physician for the aforementioned personnel.	I 206		
I 226	3510.5(c) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Surveyor: 27828 Based on observation, interview and review of in-service training records, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all residents and staff received effective training on infection control, for four of the four residents of the GHPID. (Residents #1, #2, #3, and #4)  The finding includes:  Observation on May 7, 2012, beginning at 4:50 p.m., revealed Resident #1 urinated on himself while sitting on the couch. Continued observation revealed the couch was soiled. Staff #2 then informed the other staff that she was going to change Resident #1. At 4:54 p.m., Staff #2 returned to the dining room with Resident #1 and began to engage him in a table top activity. During this time clients and staff were walking in the dining room. At 5:02 p.m., the surveyor informed Staff #2 that the couch was soiled. The staff then stated "I know I'm going to do it." The qualified intellectual disabilities professional (QIDP) overheard the conversation and instructed	I 226	I 226  To ensure proper infection control procedures, the facility RN will provide in-service training to all staff on Universal Precaution and Infection Control policies and procedures who were not present for the annual refresher training by 6/5/12. Additionally, Universal Precaution and Infection Control refresher training will continue to occur on an annual or as needed basis for all employees. Facility RN, QIDP, and Program Manager will conduct periodic monitoring of the environment to ensure sanitary conditions and proper infection control procedures are implemented.	6/5/12- Ongoing

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I 226	Continued From page 3  the staff to disinfect the couch.  Review of the training records on May 8, 2012, at approximately 2:30 p.m., revealed that staff was trained on infection control on July 23, 2011.  Interview with the registered nurse coordinator on May 8, 2012, at 9:35 a.m., revealed the staff was required to clean the soiled area immediately.  There was no evidence that proper infection control procedures were implemented.	I 226	I 226  See Response to I 226 on page 3 of 5.		
I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  This Statute is not met as evidenced by: Surveyor: 27828 Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR) and first aid, for two of nine employees. (Employees #1 and #9)  The finding includes:  Review of the personnel records on May 8, 2012, beginning at 3:00 p.m., revealed the GHPID failed to have available for review a current first aid and CPR certification for Employees #1 and #9. This was confirmed by the House Manager on the	I 227	I 227  All staff had current CPR and First Aid cards. However, cards were not copied and filed in staff records. Those cards were copied and placed in the staff records on 5/21/12.  M.O.P. Human Resource Department and the Professional Development Coordinator will ensure that all staff and consultants secure current CPR and First Aid certification to ensure the health and safety of its individuals. These certificates will be maintained in the staff personnel files for review. In cases when staff that are not in compliance, they will be placed on administrative leave. Additionally, quality assurance monitoring will review a random sample of personnel files quarterly to ensure compliance.	5/21/12- Ongoing	

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I 227	Continued From page 4 same day at approximately 3:30 p.m.	I 227			