

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

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2014
NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020		
(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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from January 29, 2014 through January 31, 2014. A sample of three clients was selected from a population of six females with varying degrees of intellectual disabilities. This survey was conducted utilizing the full survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHID Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Primary Care Physician-PCP Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Range of Motion - ROM Department of Health/Health Regulation and Licensing Administration-DOH/HRLA</p>	W 000			
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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</p>	W 153			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **2/25/14**

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 153	<p>Continued From page 1 officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an injury of unknown origin (broken femur) was reported to the DOH, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On January 29, 2014, at 1:55 p.m., review of the facility's unusual incidents revealed that on September 23, 2013, the staff informed the nurse on duty that Client #3 was screaming and crying. Upon assessment by the nurse, Client #3 was observed to have a swollen knee; however, the origin of the swelling could not be determined. Subsequently, the nurse notified the PCP and he referred Client #3 to the ER, where she was diagnosed with a broken femur.</p> <p>On January 29, 2014, at 2:13 p.m., review of the facility's investigation report dated October 18, 2013, revealed that the origin of Client #3's injury was unknown.</p> <p>On January 29, 2014, at 2:29 p.m., further review of the incident report dated September 23, 2013, revealed it documented that DOH was notified on September 23, 2013; however, there was no record to confirm the incident report was transmitted to DOH.</p> <p>Interview with the QIDP on January 29, 2014, at 2:25 p.m., indicated that the incident was reported to DOH, on September 23, 2013, as required; however, the QIDP was unable to</p>	W 153	<p>W153 VOAC will ensure that all staff in this home are retrained on the procedures for reporting incidents to all concerned per policy and regulatory requirements. The Incident management coordinator will ensure reports to DOH are done timely and in accordance with the regulations. Responsible persons are Incident Manager and QIDP for this facility.</p> <p>By 3/10/14</p>	

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W 153	Continued From page 2. provide evidence to verify that the incident was reported. At the time of the survey, the facility failed to provide evidence that Client #3's injury of unknown origin (broken femur) was reported immediately to the DOH, as required.	W 153			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0272	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2014
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 29, 2014 through January 31, 2014. A sample of three residents was selected from a population of six females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Day Program Staff - DPS Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Primary Care Physician-PCP Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Range of Motion - ROM Department of Health/Health Regulation and Licensing Administration-DOH/HRLA</p>	1.000		
1 090	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p>	1 090		

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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1090	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to maintain the exterior environment in accordance with the needs of six of six residents of the facility. (Residents #1, #2, #3, #4, #5, and #6)</p> <p>The finding includes:</p> <p>On January 31, 2014, beginning at 1:27 p.m., FC #1 accompanied the surveyor to conduct an inspection of the environment.</p> <p>Observation of a vinyl cap lying on the ground beside the facility revealed that it had a hole in the top of it. Further observation of the area revealed there was a hole in the ground that contained an underground pipe, beside the cap.</p> <p>On the same day at 2:17 p.m., interview with the maintenance staff at the facility, revealed that the vinyl cap should not have a hole in it. The maintenance staff further informed the surveyor that the cap was required to cover the end of the aforementioned underground pipe, which provides access to the facility's plumbing system.</p> <p>At the time of the survey, there was no evidence that the facility maintained the cap required to cover the end of the underground plumbing access pipe in good condition.</p>	1090	<p>3504.1 Housekeeping</p> <p>VOAC maintenance and compliance personnel examined the pipe noted in the report and found it was a water pipe and the cap with the hole is designed for that pipe. VOAC has reinstalled the vinyl cap to cover the pipe. Residential coordinator will, as part of the required facility checklist, monitor this cited issue to ensure the cover remains securely in place.</p> <p>By 2/28/14</p>	
1379	<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</p>	1379		

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1379	<p>Continued From page 2</p> <p>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 review of resident records, including incident reports and investigations, the GHIID failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, DOH/HLRA, for two of the six residents of the facility. (Residents #3 and #4)</p> <p>The findings include:</p> <p>The GHIID failed to notify DOH/HLRA timely of all significant medical incidents, as follows:</p> <p>1. On January 29, 2014, at 1:55 p.m., review of the facility's unusual incidents revealed that on September 23, 2013, the staff informed the nurse on duty that Resident #3 was screaming and crying. Upon assessment by the nurse, Resident #3 was observed to have a swollen knee; however, the origin of the swelling could not be determined. Subsequently, the nurse notified the PCP and he referred Resident #3 to the ER, where she was diagnosed with a broken femur.</p> <p>On January 29, 2014, at 2:13 p.m., review of the facility's investigation report dated October 18, 2013, revealed that the origin of Resident #3's injury was unknown.</p> <p>On January 29, 2014, at 2:29 p.m., further review</p>	1379	<p>3519.10 Emergencies</p> <p>VOAC will ensure that all staff members are retrained on the procedures for reporting incidents to all concerned per policy and regulatory requirements. The Incident management coordinator will ensure reports to DOH are done timely and in accordance with the regulations. Responsible persons are Incident Manager and QIDP for this facility by 3/10/14</p>	

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1379	<p>Continued From page 3</p> <p>of the incident report dated September 23, 2013, revealed it documented that DOH was notified on September 23, 2013; however, there was no record to confirm the incident report was transmitted to DOH.</p> <p>Interview with the QIDP on January 29, 2014, at 2:25 p.m., indicated that the incident was reported to DOH, on September 23, 2013, as required; however, the QIDP was unable to provide evidence to verify that the incident was reported.</p> <p>At the time of the survey, the facility failed to provide evidence that Resident #3's injury of unknown origin (broken femur) was reported immediately to the DOH, as required.</p> <p>2. On January 29, 2014, at 2:20 p.m., the review of an incident dated July 29, 2013, revealed Resident #3 had an unplanned emergency inpatient hospitalization due to blood in her stool. Further review of the incident report revealed it documented that DOH was notified on August 15, 2013 of the resident's hospitalization.</p> <p>Interview with the facility's QIDP on January 31, 2014, at 2:32 p.m., revealed no record was available to verify DOH notification before August 15, 2013 of Resident #3's hospitalization.</p> <p>At the time of the survey, the facility failed to ensure that Resident #3's emergency room/inpatient hospitalization was reported to DOH by telephone immediately and followed up with written notification within twenty-four (24) hours or the next work day.</p> <p>3. On January 29, 2014, at 2:29, the review of an incident report dated April 29, 2013, revealed that</p>	1379		

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1379	<p>Continued From page 4</p> <p>Resident #4's gastrostomy tube became dislodged. The resident was evaluated at the emergency room and the tube was replaced.</p> <p>Interview with the facility's QIDP on January 31, 2014, at 2:32 p.m., revealed no record was available to verify DOH notification of Resident #4's emergency room visit.</p> <p>At the time of the survey, there was no evidence Resident #4's emergency room visit was reported to DOH by telephone immediately and followed up with written notification within twenty-four (24) hours or the next work day.</p>	1379		