

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/21/2013
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 815 FLORAL PL, NW WASHINGTON, DC 20012
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I 000	INITIAL COMMENTS	I 000		
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A licensure survey was conducted on June 20, 2013 through June 21, 2013. A random sample of two residents was selected from a resident population of four females with varying degrees of intellectual disabilities.

The survey findings was based on observations in the home, interviews with administrative management, nursing and direct care staff, and the review of resident and administrative records, including incident reports.

[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]

I 379	3519.10 EMERGENCIES	I 379	<p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
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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.

This Statute is not met as evidenced by:
Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure unusual incidents that interfered substantially with the resident's health were reported immediately to the Department of Health, Health Regulation and Licensing

Our QDDP's are required to submit a faxed copy of all incident reports to Dept. of Health, addressed to [redacted] fax # 202-442-4924. Further our Incident Management Coordinator will provide oversight to ensure compliance. 7-30-13

Health Regulation & Licensing Administration

Michael [Signature]

TITLE *Program Director* (X6) DATE *8/1/13*

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

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I 379	Continued From page 1	I 379		
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Administration (DOH/HRLA), for one of two residents in the sample. (Resident #1)

The finding includes:

Review of the GHIID's incident reports on June 20, 2013, beginning at 10:10 a.m., revealed Resident #1 was transported to a local emergency room on March 8, 2013 and diagnosed with a furuncle (boil) and prescribed Cipro. [Also See 3520.3, #1, a-e]

At the time of the survey, there was no documented evidence that the aforementioned incident involving Resident #1 was reported to DOH within 24 hours as required.

I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		
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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:
Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure residents were provided with treatment services recommended for one of two residents in the sample. (Resident #1)

The findings include:

I. Review of the facility's incident reports on June 20, 2013, beginning at 9:44 a.m. revealed Resident #1 to a local emergency room on March 8, 2013. The report also revealed Resident #1

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I 401	Continued From page 3 record revealed a follow-up nursing note to the emergency room visit dated March 9, 2013. The nursing note revealed the resident verbalized discomfort in her pubic area, and was advised to rest and was administered one tablet of Bactrin 500 mg. The note failed to reflect if Resident #1 was provided with the sitz baths/warm compresses as recommended. e. According to the resident's medical record, the resident was seen by her primary care physician (PCP) on March 12, 2013. The consult revealed the resident's furuncle resolved and she was permitted to return to her day program. It should be noted that the resident had to stay home from her day program for four days due to the discomfort of the furuncle. At the time of the survey, interview and record review failed to evidence if Resident #1 received the sitz baths/warm compresses as recommended. II. Review of Resident #1's medical record on June 20, 2013, at 11:20 a.m. revealed a PCP consult dated August 28, 2012. The consult revealed a lab requisition for a urinalysis to rule-out a urinary tract infection. The consult also revealed lab work was done on the same day, (August 28, 2012), however, there was no documented evidence of the lab results in the residents' record. a. Further review of the resident's record revealed another PCP consult dated August 30, 2012. The PCP consult revealed the resident was experiencing urinary frequency. Resident #1's PCP wrote a prescription to order urine for a culture and sensitivity study (C and S) to rule out a urinary tract infection. b. A monthly nursing note dated August 31, 2012	I 401	d.) See 1401.I. b. e.) See 1401.I. b. II a.) Upon review of Individual's #1 record (medical) there was no indication that the C&S lab request was completed. To ensure that all medical recommendations are completed our LPN's are required to review medical records at least monthly and		

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1401	Continued From page 4 was reviewed on June 20, 2013 at approximately 11:30 a.m. Review of the nursing notes failed to reflect the urine C and S lab study recommended for Resident #1. c. Review of Resident #1's medical record on June 20, 2013, at 11:40 a.m. revealed a PCP consult dated September 8, 2012. The PCP's findings revealed the resident continued to display urinary frequency. The PCP ordered a second C and S to be conducted for the resident. Review of the resident's record on June 20, 2013, at 10:42 a.m. revealed a lab was conducted on September 28, 2012, however, review of the lab failed to evidence any tests of urine for C and S. III. Review of Resident #1's medical record on June 20, 2013, at 12:00 p.m. revealed PCP consult dated December 20, 2012. Further review of the consult revealed the PCP ordered the resident for the third time to get a test of urine for C and S. The PCP indicated in her findings that the resident had a vaginal odor. At the the time of the survey, the facility failed to ensure Resident #1 received test for C and S as recommended by her PCP. IV. The GHIID failed to ensure Resident #1 was provided with on-going assistance with her oral hygiene as evidenced below: a. Review of the resident's medical record on June 21, 2013, at 11:58 a.m. revealed she was seen by the dentist on July 2, 2012. Further review of the record revealed the dentist prescribed an electric toothbrush with assistance and Peridex Mouthwash. b. On October 10, 2012, the dental consult revealed the resident received gross scaling and	1401	II a. cont. provide a report to indicate completion of recommendations or provide status. 2 nd our RN's are required to review records at least quarterly and provide oversight of the LPN's monthly's. Finally our interdisciplinary team quarterly will review individuals' record to ensure completion and provide additional oversight of RN. II. b. See 1401. II a. II. c. See 1401. II a. III. See 1401. II a. IV. a. Upon review of records an interview with staff we have determined that individual	7-17-13 7-17-13 7-17-13 7-17-13

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1401	Continued From page 5 debridement. The consult also revealed that Resident #1 needed improvement in her oral hygiene and needed an electric toothbrush. c. On October 24, 2012, Resident #1 was seen again by her dentist and the recommendation for an electric toothbrush with assistance was repeated. d. On January 3, 2013, Resident #1 had a dental appointment and received gross scaling and debridement. The dental consult also revealed the "resident must be assisted with brushing daily. Interview with the staff on June 21, 2013, at 12:05 p.m. revealed Resident #1 was provided hand over hand assistance with brushing her teeth. Continued discussion with the staff revealed the resident had an electric toothbrush in the past, however, at the time of the survey, Resident did not have an electric toothbrush.	1401 Cont.	#1 had a electric tooth-brush that had become unsanitary and mal-functioning on 6-20-13 and was replaced on 6-21-13 and is in the facility available for review. IV. b. see 1401, IV. a. 6-21-13 IV. c. see 1401, IV. a. 6-21-13 IV. d. see 1401, IV. a. 6-21-13	6-21-13
1500	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 interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure each resident's rights were observed and protected in accordance with D.C. Law, Title 7, Chapter 13 (formerly D.C. Law 2-137), this chapter, and other applicable District and Federal Laws, for one of two residents in the	1500	# 1 cont. Additionally Facility Managers are required weekly to inspect Indid Individual's personal care items to ensure that they are available and working. This is part of the checklist that is done weekly and reviewed	7-30-13

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1500	Continued From page 6 sample. (Resident #1) The findings include: (Chapter 13, § 7-1305.05. formerly § 6-1965 (h). Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication. (g) Each customer shall have the right to prompt and adequate medical attention for any physical ailments. The GHIID failed to ensure Resident #1 was provided with a sitz bath/warm compresses to relieve the discomfort of a furuncle (boil) on the resident's labia. Additionally, the GHIID failed to ensure medical recommendations were conducted to include a urine culture and sensitivity (C and S) to rule out a urinary tract infection. The GHIID also failed to ensure Resident #1 was provided with on-going assistance with her oral hygiene. [See also 3520.3]	1500	See 1401.b., 1401 II a and 1401.W.a.	7-17-13