

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2012
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NAME OF PROVIDER OR SUPPLIER WARD & WARD	STREET ADDRESS, CITY, STATE, ZIP CODE 823 FERN PL, NW WASHINGTON, DC 20012
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1 000 INITIAL COMMENTS

1 000

A licensure survey was conducted on July 12, 2012. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home, interviews with direct support staff, nursing and administrative staff, as well as a 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.]

1 090 3504.1 HOUSEKEEPING

1 090

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 facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was maintained in a safe and orderly manner for four of four residents in the facility. (Residents #1, #2, #3, and #4,)

The findings include:

On July 12, 2012, beginning at approximately 11:45 a.m., the qualified intellectual disabilities professional (QIDP), accompanied the surveyor through the facility to conduct the environmental inspection.

Facility Managers weekly are required to complete a facility checklist to ensure safe, clean, orderly, attractive and sanitary conditions free of dirt, rubbish and objectionable odors. Additionally the maintenance department has made the following corrections:

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

Michael Warr

TITLE

Program Director

(X6) DATE

8-1-12

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I 090	Continued From page 1 The following concerns were identified: 1. The closet door in Resident #4's bedroom is off track. 2. The living room seat cushion is torn. In addition there were several brown stains observed on the carpet. 3. The kitchen cabinet next to the dishwasher is missing the front panel. 4. Vents located in the dinning room and kitchen are broken and have evidence of rust.	I 090	<i>Cont.</i> 1. Closet door in individual #4 bedroom was repaired. 2. Livingroom seat replaced and carpet cleaned by 8-10-12. 3. Repair kitchen cabinet next to dishwasher by 8-10-12 4. Replace vents located in dinningroom and kitchen by 8-10-12.	7-31-12	
I 379	3519.10 EMERGENCIES 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 persons with individual disabilities (GHPID) failed to ensure unusual incidents that interfered substantially with a resident's health were reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), for one of the two residents living in the facility. (Resident #4)	I 379			

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I 379 Continued From page 2

I 379

The finding includes:

Review of the GHPID's incident reports on July 12, 2012, beginning at approximately 8:30 a.m., revealed Resident #4 was involved in an incident dated May 17, 2012. Further review of the report revealed the resident was wheezing and experiencing difficulty with his breathing at the day program. Interview with the House Manager (HM) on July 12, 2012 at approximately 8:33 a.m., revealed the resident had been exposed to some cleaning solution that was too strong.

Interview with the qualified intellectual disabilities professional (QIDP) on July 12, 2012, at approximately revealed that she was responsible for reporting the incidents to the Department of Health. A pre-survey review of incidents reported to the State agency revealed that we received notification of the aforementioned incident on May 22, 2012.

At the time of the survey, the GHPID failed to ensure the Department of Health, Health Regulations and Licensing Administration Division (DOH/HRLA) was notified of the incident involving Resident #4 within twenty-four hours as required.

Please find attached the incident report for individual #4, dated 5-18-12 not 5-17-12. The 18th was a Friday and it was entered into MCIS on 5-19-12, Saturday. DOH was notified on Tuesday 5-22-12 as the QDDP was not in the office on Monday 5-21-12. All incidents are to be communicated to DOH within 24 hrs or next business day.

7-31-12

I 432 3521.7(c) HABILITATION AND TRAINING

I 432

The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:

(c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);

This Statute is not met as evidenced by:

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I 432 Continued From page 3

Based on staff interview and record review, the facility failed to ensure each resident's individual program plan (IPP) included training in activities of dental hygiene, for one of the two residents included in the sample. (Resident #2)

The finding includes:

Review of Resident #2's medical record on July 12, 2012 at approximately 1:44 p.m., revealed three dental consultations dated October 12, 2011, April 9, 2012, and April 16, 2012. The dental consult dated October 12, 2011 revealed the resident needed assistance with brushing and was diagnosed with a Periodontal abscess. The resident was prescribed Peridex Mouthwash to rinse bid (twice a day) and spit. According to the April 9, 2012 consult, the dentist recommended the resident floss and brush his teeth 2 times daily with assistance. April 16, 2012's consult also revealed the resident "must brush and floss with assistance twice a day."

Interview with the qualified intellectual disabilities professional (QIDP) on July 12, 2012, at approximately 2:33 p.m., revealed Resident #2 had a tooth brushing objective in the past, however, at the time of the survey, there was no documented evidence of a formal individual program plan (IPP) to address the resident's poor oral hygiene.

I 473 3522.4 MEDICATIONS

The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.

This Statute is not met as evidenced by:
Based on observation, interview and record

I 432

Please find attached IPP Goal to implement Oral hygiene as a formal goal to comply with the Dentist recommendation. Additionally QDDP will review medical consults monthly and Program Director Quarterly to ensure recommendations are implemented.

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I 473 Continued From page 4

verification, the Group Home for Persons with Intellectual Disability (GHPID) failed to report irregularities to the Primary Care Physician (PCP) for one of two residents included in the sample. (Resident #1)

The findings include:

Review of Resident #1's medical record on July 12, 2012, beginning at 11:39 a.m. revealed a dental consult dated March 29, 2012. The facility's registered nurse (RN) was interviewed at approximately 2:20 p.m. to ascertain information regarding the dental consult. The RN had difficulty understanding the dentist's handwriting, but believed that some of the findings included heavy calculus, heavy food debris, and positive red swelling gums.

According to the RN, the consult appeared to state that the resident needed deep scaling and sedation for treatment. The dental consult also revealed that the dentist prescribed Tetracycline 250 mg for 28 days. Review of the Medication Administration Records (MAR) failed to reveal any evidence that the medication prescribed for Resident #1 had been administered.

I 473

Please find attached Physician's Interim Telephone Orders dated 3-30-12 to substitute DOXYCYCLINE 100 mg for the TETRACYCLINE that was not in stock. Additionally attached is the March and April MAR's to indicate medication was given as prescribed.

7-31-12

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 interview and record review, the group home for persons with intellectual disabilities

I 500

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I 500	<p>Continued From page 5</p> <p>(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 other District laws that govern the care and rights of persons with mental retardation, for two residents included in the sample. (Resident #1)</p> <p>The finding includes :</p> <p>(Chapter 13, § 7-1305.05.(h)</p> <p>Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt medical attention was provided, as evidenced below:</p> <p>Review of Resident #1's medical record on July 12, 2012, beginning at 11:39 a.m. revealed a dental consult dated March 29, 2012. The facility's registered nurse (RN) was interviewed at approximately 2:20 p.m. to ascertain information regarding the dental consult. The RN had difficulty understanding the dentist's handwriting, but believed that some of the findings included heavy calculus, heavy food debris, and positive red swelling gums.</p> <p>According to the RN, the consult appeared to state that the resident needed deep scaling and sedation for treatment. The dental consult also revealed that the dentist prescribed Tetracycline 250 mg for 28 days. Review of the Medication Administration Records (MAR) failed to reveal any evidence that the medication prescribed for Resident #1 had been administered.</p> <p>Further interview the RN and review of the record revealed authorization and consent from the guardian was needed before any further</p>	I 500	See TAG # 1473	7-31-12
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I 500	Continued From page 6 treatment could be provided. Interview with the RN and record review revealed consent from the guardian was not attempted until May 31, 2012, and again on June 11, 2012, approximately 2 1/2 months later. At the time of the survey, there was no evidence that Resident #1's dental needs were addressed timely. Note: Interview with the guardian post survey (July 13, 2012) revealed that she had received the notification from the facility, however, still needed clarity about the treatment and sedation recommended for Resident #1.	I 500		
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