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9/13/13
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PRINTED: 08/09/2013
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF-000907	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/01/2013
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NAME OF PROVIDER OR SUPPLIER NEIGHBORS CONSEJO INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 1622 LAMONT STREET, NW WASHINGTON, DC 20010
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{D 000} Initial Comments

{D 000}

A follow-up survey was conducted to determine compliance with your plan of correction submitted on May 6, 2013, for deficiencies cited on April 17, 2013.

The survey findings determined that the environment deficiencies and others were not abated as evidence in this statement of deficiencies.

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

{D 450} 3402.3 Personnel

{D 450}

All persons employed in a community residence facility shall have a pre-employment medical examination by a licensed physician and shall be certified annually by the examining physician to be in good health and free of communicable diseases as defined in chapter 2 of this title.

This CONDITION is not met as evidenced by: Based on interview and record review, the community residence facility (CRF) failed to ensure that each staff received an annual examination by a physician, and was certified by the examining physician to be in good health and free of communicable diseases for one of six personnel records reviewed. (Consultant #5, psychiatrist)

The finding includes:

On April 17, 2013, beginning at approximately 10:33 a.m., a review of the personnel records revealed Consultant #5 failed to evidence an annual medical examination.

At the time of the survey, the facility failed to ensure a current annual medical examination was available for Consultant #5.

Neighbors' Consejo through the Administrative Manager/ QI will do internal audits to ensure that all the documents needed for the staff and consultant records are present and up to date. For consultant #5 record, his medical record will be in his file in the next week.

Sept. 20
2013

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

[Handwritten Signature]

TITLE

Executive Director

(X6) DATE

9/18/13

Health Regulation & Licensing Administration

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D 900	<p>3406.1 Resident's Rights</p> <p>A supportative and protective environment shall be provided to each resident to promote his or her comfort, self-esteem, and personal dignity, and to ensure that the resident's property and civil rights are respected.</p> <p>This CONDITION is not met as evidenced by: Based on observation, the community residential facility failed to ensure that each resident was provided a supportive and protective environment to promote comfort, self-esteem and personal dignity, and to ensure that the resident's property (clothing, medications) and civil rights were respected for all residents residing in the residence.</p> <p>The findings include:</p> <p>On May 6, 2013, HRLA received Neighbor Consejo ' s plan of correction (POC) addressing the April 17, 2013 survey findings. According to the POC, the house monitor in charge, case manager and Social Services Director would conduct daily monitoring regarding the appearance and sanitary state of the house. Additionally the plan identified personnel that would utilize a specific check list and document any irregularities to discuss during the Executive Team meetings on a monthly basis; and all environmental concerns would be address by May 20, 2013.</p> <p>On August 1, 2013, a revisit was conducted to determine if all environmental concerns cited during the April 17, 2013 annual survey had been abated. It was determined that many of the April 17, 2013 environmental deficiencies remained</p>	D 900		
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D 900	<p>Continued From page 2</p> <p>and new deficiencies were identified.</p> <p>1. During the environmental inspection on August 1, 2013, beginning at approximately 10:20 a.m., the following findings were identified:</p> <p>A. Bedrooms:</p> <p>Observations of the residence revealed three bedrooms.</p> <p>1.. Observation of the facility's rear bedroom revealed two out of two windows with no curtains or blinds. There was a bunk bed in the room with no night stands or lamps for resident use.</p> <p>2. In the middle bedroom, one of one window ' s evidenced a venetian blind that did not fit the window. Spacing between the blinds and window frame failed to provide privacy for the residents residing in the room. One of two bed mattress was sagging in the front, and the bed pillow was flat. One of two resident's had a metal cabinet for clothing and neither of the residents had bedside lamps. Only one of the two residents had a night stand.</p> <p>3. Observations of the front bedroom revealed one of three bed mattress sagging. There was one night stand, and one lamp. There were no night stands or bedside lamp for the other two residents.</p> <p>4. A bed positioned in the middle of the room had a rectangle coffee table approximately three (3) feet long placed beside the bed that held personal items.</p> <p>There were also two crates stacked on top of each other that appeared to be used as a night</p>	D 900	<p>Neighbors' Consejo has bought and given each resident the following: night stand and beside lamps.</p> <p>Neighbors' Consejo has also put new curtains on each window to assure the privacy of the residents.</p> <p>Neighbors' Consejo will provide new pillows for the residents. The Social Services Director will be in charge of this task.</p>	<p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p>
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D 900	<p>Continued From page 3</p> <p>stand. There was also no bed lamp observed.</p> <ul style="list-style-type: none"> - The bedroom closet was small and did not appear to have ample space for all three residents' personal belongings residing in the room. - A four drawer file cabinet used as furniture that held resident's clothing was located in the bedroom. - There was a box sitting on the floor with clothing items next to a metal chair. <p>B. Bathroom:</p> <ol style="list-style-type: none"> 1. In the bathroom there was no towels, soap, or hand cleaner. 2. There was no curtains or blinds at the window to ensure privacy. 3. The mirror in the bathroom was observed hanging with a piece of string over a nail. <p>C. Kitchen:</p> <ol style="list-style-type: none"> 1. Observation of the facility's kitchen window located near the sink had no curtains or blinds. Additionally, there was no curtain covering for the kitchen door window. 2. In one of two refrigerators there was raw food uncovered on the top shelf. There were no thermostats in the refrigerators to determine the temperature for food storage. 3. A soiled dish cloth that was hanging on the 	D 900	<p>Neighbors' Consejo bough an extra closet in order to provide more space for the residents to keep their belongings. The room has been organized and residents belongings are stored in the proper place.</p> <p>Neighbors' Consejo has bought towels, soap and it has installed a curtain to maintain residents' privacy. The mirror has been hanged properly.</p> <p>Neighbors' Consejo has installed curtains on all kitchen windows.</p> <p>Neighbors' Consejo has cleaned the kitchen and has bought a thermostat for the refrigerator.</p>	<p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p> <p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p>

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D 900	<p>Continued From page 4</p> <p>handle of the stove.</p> <p>5. Two of two kitchen trash cans were observed without lids or covers. Trash was observed in both trash cans.</p> <p>6. Two dining room chairs had torn and soiled cushions.</p> <p>D. Backyard:</p> <p>1. A mattress was observed sitting on two patio chairs in the backyard.</p> <p>2. An exit sign, a worn broom, rusted can of paint, an aluminum bowl with an empty soda can and an empty energy drink can were observed stacked up on the back porch. Additionally, a plastic top for a container was lying on the back porch.</p> <p>II. The facility failed to ensure each of the residents' medications was secured as evidenced below:</p> <p>A. On April 17, 2013 at 12:19 p.m., record review revealed Resident #1 had a medication log documenting that he was prescribed Quetiapina 25 milligrams (mg). A prescription dated March 22, 2013, revealed the resident was also prescribed Seroquel 25 mg. Interview with the facility's case manager and the administrator manager on April 17, 2013, at 12:44 p.m. revealed the resident's medications were stored in the resident's night stand. Observations during the inspection of the environment on April 17,</p>	D 900	<p>Neighbors' Consejo has change the dining room chairs and has covered the trash cans.</p> <p>Neighbors' Consejo has clean the backyard of all the unnecessary items that were found. The backyard has been clean.</p> <p>Neighbors' Consejo will provide each resident with a locker specifically to secure and separate its' medication from the other residents. Each locker will have its own combination or lock which will be given to each resident from the first day of moving to the facility. At the moment Neighbors' Consejo provides medication management groups to avoid incidents regarding medication.</p>	<p>Sept. 20, 2013</p> <p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p>
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D 900	<p>Continued From page 5</p> <p>2013, beginning at 3:44 p.m. revealed no evidence of Resident #1's medication. It should be noted that both managers were looking for the resident's medication in his dresser drawer, however, at the time of the environmental walk-through there was no evidence of the whereabouts of Resident #1's medications. A review of Resident #1's record on April 17, 2013, beginning at 12:19 p.m. revealed a Medication log including the following medications: Quetiapina 25 milligrams (mg), and Seroquel 25 mg.</p> <p>B. Observations on April 17, 2013, at 4:20 p.m. revealed Resident #2's medications were observed in his nightstand. The following medications were observed: Quetiapine Fumarate 25 mg, Clopidogrel 75 mg, Foxetine HCL 30 mg, Risperdal 3 mg, Omeprazole DR 20 mg and Cymbalta 30 mg. Although the Cymbalta was observed in Resident #2's nightstand, there was no label to identify who the medication had been prescribed for. Interview with the CRF's psychiatrist post survey on April 18, 2013, revealed the reason Cymbalta did not have a label was because it was a sample.</p> <p>C. Observation of Resident #3's medications on April 17, 2013, at 4:26 p.m. revealed the resident's medications were sitting on top of his dresser. The medications included Loratadine 10 mg, Aspirin 81 mg, Trazadone 100 mg, Simvastatin 10 mg, Quetiapine 25 mg, Cymbalta 30 mg, Metformin HCL 850 mg, a bottle of Hypo Tears without a label identifying if the medication had been prescribed for Resident #3.</p> <p>D. Continued observations during the environmental inspection on April 17, 2013,</p>	D 900	<p>Neighbors' Consejo will provide each resident with a locker specifically to secure and separate its' medication from the other residents. Each locker will have its own combination or lock which will be given to each resident from the first day of moving to the facility.</p> <p>At the moment Neighbors' Consejo provides medication management groups to avoid incidents regarding medication.</p>	Sept. 20 2013
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D 900	<p>Continued From page 6</p> <p>beginning at 3:44 p.m. revealed Resident #4's medications sitting on a table in his bedroom next to his bed. The medications observed on the aforementioned table included Quetiapine 25 mg, HCTZ 25 mg, Lisinopril 40 mg, and Naproxen 500 mg.</p> <p>Interview with the case manager on April 17, 2013, at 3:46 p.m. revealed that each resident upon completion of detoxification moves to the transitional home (CRF). Further interview revealed the residents are responsible for self administration of their individual medications. Additionally, the facility does not provide monitors for the transitional home. The interview revealed that the facility had a medical director/psychiatrist on staff to conduct a medical assessment for each resident and prescribed medication.</p> <p>E. Observation of Resident #5's medications on April 17, 2013, at 5:01 p.m. revealed Pancrelipas Delayed Release Caps, and Propranolol 10 mg was observed in his nightstand.</p>	D 900	<p>Neighbors' Consejo will provide each resident with a locker specifically to secure and separate its' medication from the other residents. Each locker will have its own combination or lock which will be given to each resident from the first day of moving to the facility.</p> <p>At the moment Neighbors' Consejo provides medication management groups to avoid incidents regarding medication.</p>	Sept. 20, 2013
(D1700)	<p>3416.1 Medication Storage and Disposal</p> <p>The community residence facility shall provide each resident with a means for keeping his or her medications secure and separate from those of other persons.</p> <p>This CONDITION is not met as evidenced by: Based observation, and interview, the community residence facility (CRF) failed to ensure each of the residents' medications was secured for five of six residents residing included in the sample. (Residents #1, #2, #3, #4, and #5)</p> <p>The findings include:</p>	(D1700)		

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{D1700}	<p>Continued From page 7</p> <p>The facility failed to ensure each of the residents' medications was secured as evidenced below:</p> <ol style="list-style-type: none"> On April 17, 2013 at 12:19 p.m., record review revealed Resident #1 had a medication log documenting that he was prescribed Quetiapina 25 milligrams (mg). A prescription dated March 22, 2013, revealed the resident was also prescribed Seroquel 25 mg. Interview with the facility's case manager and the administrator manager on April 17, 2013, at 12:44 p.m. revealed the resident's medications were stored in the resident's night stand. Observations during the inspection of the environment on April 17, 2013, beginning at 3:44 p.m. revealed no evidence of Resident #1's medication. It should be noted that both managers were looking for the resident's medication in his dresser drawer, however, at the time of the environmental walk-through there was no evidence of the whereabouts of Resident #1's medications. A review of Resident #1's record on April 17, 2013, beginning at 12:19 p.m. revealed a Medication log including the following medications: Quetiapina 25 milligrams (mg), and Seroquel 25 mg. Observations on April 17, 2013, at 4:20 p.m. revealed Resident #2's medications were observed in his nightstand. The following medications were observed: Quetiapine Fumarate 25 mg, Clopidogrel 75 mg, Foxetine HCL 30 mg, Risperdal 3 mg, Omeprazole DR 20 mg and Cymbalta 30 mg. Although the Cymbalta was observed in Resident #2's nightstand, there was no label to identify who the medication had been prescribed for. Interview with the CRF's psychiatrist post survey on April 18, 2013, revealed the reason Cymbalta 	{D1700}	<p>Neighbors' Consejo will provide each resident with a locker specifically to secure and separate its' medication from the other residents. Each locker will have its own combination or lock which will be given to each resident from the first day of moving to the facility.</p> <p>At the moment Neighbors' Consejo provides medication management groups to avoid incidents regarding medication.</p>	<p>Sept. 20, 2013</p>
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{D1700}	<p>Continued From page 8</p> <p>did not have a label was because it was a sample.</p> <p>3. Observation of Resident #3's medications on April 17, 2013, at 4:26 p.m. revealed the resident's medications were sitting on top of his dresser. The medications included Loratadine 10 mg, Aspirin 81 mg, Trazadone 100 mg, Simvastatin 10 mg, Quetiapine 25 mg, Cymbalta 30 mg, Metformin HCL 850 mg, a bottle of Hypo Tears without a label identifying if the medication had been prescribed for Resident #3.</p> <p>4. Continued observations during the environmental inspection on April 17, 2013, beginning at 3:44 p.m. revealed Resident #4's medications sitting on a table in his bedroom next to his bed. The medications observed on the aforementioned table included Quetiapine 25 mg, HCTZ 25 mg, Lisinopril 40 mg, and Naproxen 500 mg.</p> <p>Interview with the case manager on April 17, 2013, at 3:46 p.m. revealed that each resident upon completion of detoxification moves to the transitional home (CRF). Further interview revealed the residents are responsible for self administration of their individual medications. Additionally, the facility does not provide monitors for the transitional home. The interview revealed that the facility had a medical director/psychiatrist on staff to conduct a medical assessment for each resident and prescribed medication.</p> <p>5. Observation of Resident #5's medications on April 17, 2013, at 5:01 p.m. revealed Pancrelipas Delayed Release Caps, and Propranolol 10 mg was observed in his nightstand.</p> <p>At the time of the survey, the CRF failed to</p>	{D1700}	<p>Neighbors' Consejo will provide each resident with a locker specifically to secure and separate its' medication from the other residents. Each locker will have its own combination or lock which will be given to each resident from the first day of moving to the facility.</p> <p>At the moment Neighbors' Consejo provides medication management groups to avoid incidents regarding medication.</p>	<p>Sept. 20, 2013</p>
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{D1700}	Continued From page 9 ensure Residents #1, #2, #3, #4, and #5 were provided with a place to secure their medications.	{D1700}		
{D3000}	<p>3421.1 Housekeeping and Laundry Services</p> <p>The interior and exterior of each community residence facility shall be maintained in a safe, clean, orderly, attractive, and sanitary manner free from accumulations of dirt, rubbish, and objectionable odors.</p> <p>This CONDITION is not met as evidenced by: On May 6, 2013, HRLA received Neighbor Consejo 's plan of correction (POC) addressing the April 17, 2013 survey findings. According to the POC, the house monitor in charge, case manager and Social Services Director would conduct daily monitoring regarding the appearance and sanitary state of the house. Additionally the plan identified personnel that would utilize a specific check list and document any irregularities to discuss during the Executive Team meetings on a monthly basis; and all environmental concerns would be address by May 20, 2013.</p> <p>On August 1, 2013, a revisit was conducted to determine if all environmental concerns cited during the April 17, 2013 annual survey had been abated. It was determined that many of the April 17, 2013 environmental deficiencies remained and new deficiencies were identified.</p> <p>I. During the environmental inspection on August 1, 2013, beginning at approximately 10:20 a.m., the following findings were identified:</p> <p>A. Bedrooms:</p>	{D3000}	<p>The Social Services Director will ensure that the facility is maintain in a safe, clean, orderly, sanitary and attractive manner free from accumulation of dirt, rubbish and objectionable odors.</p> <p>On a daily bases, house monitor is in charge to communicate any unacceptable findings in the house regarding the appearance and sanitary state of the house. The case manager and Social Services Director will monitor that the maintenance of the house is kept on a daily bases.</p>	Sept. 20, 2013

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{D3000}	<p>Continued From page 10</p> <p>Observations of the residence revealed three bedrooms.</p> <p>1.. Observation of the facility's rear bedroom revealed two out of two windows with no curtains or blinds. There was a bunk bed in the room with no night stands or lamps for resident use.</p> <p>2. In the middle bedroom, one of one window ' s evidenced a venetian blind that did not fit the window. Spacing between the blinds and window frame failed to provide privacy for the residents residing in the room. One of two bed mattress was sagging in the front, and the bed pillow was flat. One of two resident's had a metal cabinet for clothing and neither of the residents had bedside lamps. Only one of the two residents had a night stand.</p> <p>3. Observations of the front bedroom revealed one of three bed mattress sagging. There was one night stand, and one lamp. There were no night stands or bedside lamp for the other two residents.</p> <p>4. A bed positioned in the middle of the room had a rectangle coffee table approximately three (3) feet long placed beside the bed that held personal items.</p> <p>There were also two crates stacked on top of each other that appeared to be used as a night stand. There was also no bed lamp observed.</p> <p>The bedroom closet was small and did not appear to have ample space for all three residents ' personal belongings residing in the room.</p> <p>A four drawer file cabinet used as furniture</p>	{D3000}	<p>Neighbors' Consejo has bought and given each resident the following: night stand and beside lamps.</p> <p>Neighbors' Consejo has also put new curtains on each window to assure the privacy of the residents.</p> <p>Neighbors' Consejo will provide new pillows for the residents. The Social Services Director will be in charge of this task.</p>	<p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF-000907	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/01/2013
NAME OF PROVIDER OR SUPPLIER NEIGHBORS CONSEJO INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1622 LAMONT STREET, NW WASHINGTON, DC 20010		
(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
{D3000}	Continued From page 11 that held resident's clothing was located in the bedroom. There was a box sitting on the floor with clothing items next to a metal chair. B. Bathroom: 1. In the bathroom there was no towels, soap, or hand cleaner. 2. There was no curtains or blinds at the window to ensure privacy. 3. The mirror in the bathroom was observed hanging with a piece of string over a nail. C. Kitchen: 1. Observation of the facility's kitchen window located near the sink had no curtains or blinds. Additionally, there was no curtain covering for the kitchen door window. 2. In one of two refrigerators there was raw food uncovered on the top shelf. There were no thermostats in the refrigerators to determine the temperature for food storage. 3. A soiled dish cloth that was hanging on the handle of the stove. 5. Two of two kitchen trash cans were observed without lids or covers. Trash was observed in both trash cans. 6. Two dining room chairs had torn and soiled cushions.	{D3000}	Neighbors' Consejo bough an extra closet in order to provide more space for the residents to keep their belongings. The room has been organized and residents belongings are stored in the proper place. Neighbors' Consejo has bought towels, soap and it has installed a curtain to maintain residents' privacy. The mirror has been hanged properly. Neighbors' Consejo has installed curtains on all kitchen windows. Neighbors' Consejo has cleaned the kitchen, replaced the soiled dish cloth and has bought a thermostat for the refrigerator. Neighbors' Consejo has change the dining room chairs and has covered the trash cans.	Sept. 6, 2013 Sept. 20, 2013 Sept. 6, 2013 Sept. 20, 2013 Sept. 20, 2013

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{D3000}	<p>Continued From page 14</p> <p>to the facility's kitchen was also observed with peeling paint.</p> <p>5. The kitchen wall and the kitchen floor were observed to be soiled.</p> <p>6. A large area of the kitchen ceiling was observed with patch work left unpainted.</p> <p>Bathroom:</p> <p>1. Observation of the second floor bathroom revealed several cracks in the tile on the wall. It appeared that the facility had started to repair some of the cracks but did not complete the job.</p> <p>2. The bathroom wall and the bathroom light switch were black and dirty. The bathroom tub was observed with an accumulation of soap scum.</p> <p>3. The mirror in the bathroom was observed hanging with a piece string over a nail.</p> <p>4. The ceiling fan's vent located in the facility's bathroom was observed to be dirty and the opening of the vent was filled with dust.</p> <p>5. The bathroom window was observed without a venetian blind and/or curtain.</p> <p>Backyard:</p> <p>1. A mattress was observed sitting on two patio chairs in the backyard.</p> <p>2. An exit sign, a warned broom, rusted can of paint, an aluminum bowl with an empty soda can and an empty energy drink can were observed on the back porch. Additionally, a plastic top for a</p>	{D3000}	<p>Social Services Director, case manager and house monitors will be in charge of assuring that the kitchen and the entire house is kept clean.</p> <p>Social Services Director is in charge of assuring that all the necessary repairs get completed.</p> <p>Social Services Director, case manager and house monitors will be in charge of assuring that the bathroom and the entire house is kept clean.</p> <p>Social Services Director is in charge of assuring that all the necessary repairs get completed.</p> <p>Neighbors' Consejo has bought and installed curtains for the bathroom.</p> <p>Neighbors' Consejo has clean the back yard of all the unnecessary items that were found. The backyard has been clean.</p>	<p>Sept. 27, 2013</p> <p>Sept. 27, 2013</p> <p>Sept. 6, 2013</p> <p>Sept. 6, 2013</p>

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{D3000}	Continued From page 15 container was lying on the back porch.	{D3000}		
D4710	<p>3431.2 Bedrooms</p> <p>Every resident's bedroom shall be equipped or provided with a bed, a bedside table or cabinet with an individual reading lamp with at least a seventy-five (75) watt bulb, a comfortable armchair, and suitable, sufficient storage space for each resident's personal clothing and personal effects.</p> <p>This CONDITION is not met as evidenced by: Based on observation, the community residential facility (CRF) failed to ensure each resident was provided with a bed, bedside table, individual lamp and a sufficient storage space for each resident's personal clothing and personal effects for all residents residing in the facility.</p> <p>The findings include:</p> <p>Observations of the residence revealed three bedrooms.</p> <p>1. Observation of the facility's rear bedroom revealed a bunk bed in the room with no night stands or lamps for resident use.</p> <p>2. In the middle bedroom, one of two bed mattress was sagging in the front, and the bed pillow was flat. One of two resident's had a metal cabinet for clothing and neither of the residents had bedside lamps. Only one of the two residents had a night stand.</p> <p>3. Observations of the front bedroom revealed one of three bed mattress sagging. There was one night stand, and one lamp. There were no</p>	D4710	<p>Neighbors' Consejo has bought and given each resident the following: night stand and bedside lamps.</p> <p>Neighbors' Consejo has also put new curtains on each window to assure the privacy of the residents.</p> <p>Neighbors' Consejo will provide new pillows for the residents. The Social Services Director will be in charge of this task.</p>	<p>Sept. 6, 2013</p> <p>Sept. 20, 2013</p>

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D4710	<p>Continued From page 16</p> <p>night stands or bedside lamp for the other two residents.</p> <p>4. A bed positioned in the middle of the room had a rectangle coffee table approximately three (3) feet long placed beside the bed that held personal items.</p> <p>There were also two crates stacked on top of each other that appeared to be used as a night stand. There was also no bed lamp observed.</p> <p>The bedroom closet was small and did not appear to have ample space for all three residents' personal belongings residing in the room.</p> <p>A four drawer file cabinet used as furniture that held resident's clothing was located in the bedroom.</p> <p>There was a box sitting on the floor with clothing items next to a metal chair.</p>	D4710	<p>Neighbors' Consejo bough an extra closet in order to provide more space for the residents to keep their belongings. The room has been organized and residents belongings are stored in the proper place.</p>	Sept. 6, 2013
D4770	<p>3431.8 Bedrooms</p> <p>Each bed shall be placed at least three feet (3') from any other bed and at least three feet (3') from any radiator or window.</p> <p>This CONDITION is not met as evidenced by: Based on observation, the community residential facility (CRF) failed to ensure each residents bed was at least three (3) feet from roommates beds and placed away from windows to ensure privacy for one of one resident residing in the bedroom.</p> <p>The findings include:</p>	D4770	<p>The Social Services Director will ensure that the beds are moved with the proper spacing and safety norms.</p>	Sept. 20, 2013

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D4770	Continued From page 17 Observations conducted of the facility on August 1, 2013, beginning at approximately 10:20 a.m., revealed the facility has three bedrooms. Two of the bedrooms evidence single beds. The rear bedroom however, revealed a bunk bed that was connected with a bed on top. The bunk bed was also positioned by the bedroom window which was in violation of proper spacing in accordance with regulation.	D4770	The Social Services Director will ensure that the beds are moved with the proper spacing and safety norms.	Sept. 20, 2013