		AND HUMAN SERVI & MEDICAID SERVIC	CES			FORM.	09/07/2010 APPROVED 0938-0 <u>391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CLIM .	(X2) MULT A. BUILDIN		(X3) DATE SU COMPLE	
		09G178		8. WING		08/2	7/2010
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1307 46TH PLACE, SE		
					PROVIDER'S PLAN OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE OPRIATE	(X5) COMPLETION DATE
W 000	August 26, 2010 th utilizing the fundam random sampling of a population of four mental retardation if The findings of the observations at the programs, interview group home/day pr clinical and adminis incident/investigation 483.420(a)(7) PRO RIGHTS The facility must er Therefore, the facility treatment and care This STANDARD if Based on observat failed to ensure an clients' right for privi- administration, for the residing in the facility The finding include	vey was conducted fro rough August 27, 2010 ental survey process. If two clients was select males with various levand and disabilities. survey were based on group home and two of vs with one family men ogram staff, and the re- strative records, includi- on reports. TECTION OF CLIENT issure the rights of all cli- ity must ensure privacy of personal needs. s not met as evidence ion and interview, the f effective system to pro- vacy during medication three of the four clients ty. (Client #2, #3 and interview)	A ted from vels of ber, wiew of ng S ients. during d by: acility tect the #4)	W 000	t is the policy of this Provider that p provided during the medication administration. To ensure privacy during the medication administration, each facility has a des area where each individual is given the medication out of the presence of the individuals; however, the LPN who a the medication on August 26, 2010 a failed to provide privacy during the medic inserviced by the DON on Refer to attachment #1. In the future, the agency will ensure the nurses provide privacy during the medication.	rivacy be lion signated he other administered t 6:30am medication cation was hat the dication ion to	
	August 26, 2010, fr revealed LPN #1 ar medications in from observation reveale being administered Client #2. When int 6:55 a.m., LPN #1	g medication administr om 6:30 a.m. until 6:50 dministering Client #2's t of Client #1. Further ed Client #3 and Client their medications in fr erviewed at approxima acknowledged that Clie	a.m. #4 ont of ttely ents #2,		re-occur, the LPN supervisor will me medication pass once monthly, and the supervisor will monitor the medication quarterly basis as stipulated on the n policy. Refer to the attached policy.	ie RN on pass on a	
LABORATOR	DIRECTOR'S OR PROVID	DERISUPPLIER REPRESENT	ATIVE'S SIGNA		reducin Linpilia	(\cdot)	(X8) DATE
141 VI		AXA (2) N		11	MUM HICKNE	Ч	<u>-1 11 1</u>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution maybe 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 80 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/07/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G178	B, WIN	G	- 08/2:	7/2010
	Rovider or supplier • Washington			STREET ADDRESS. CITY, STATE, 1307 45TH PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFiX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	OTHE APPROPRIATE	(X5) COMPLETION DATE
W 130 W 149	medication adminis There was no evide during medication a 483.420(d)(1) STA CLIENTS The facility must de policies and procee	provided privacy during stration. ence that staff ensured privacy administration. FF TREATMENT OF evelop and implement written	VV 1 VV 1			
W 154	Based on interview failed to implement health and safety for the facility. (Clients The finding include Cross-refer to W18 implement its polic and serious reports 483.420(d)(3) STA CLIENTS The facility must have violations are thore This STANDARD Based on interview failed to investigate to ensure the healt	es: 54. The facility falled to y for investigating all reportable able incidents. FF TREATMENT OF ave evidence that all alleged oughly investigated. is not met as evidenced by: y and record review, the facility e serious reportable incidents h and safety of two of four he facility. (Clients #2 and #3)	W 1	54 This provider has an In Policy that prohibits m abuse of the individual It is also the the Policy that all of the incidents timely manner, and inv	istreatment, neglect or s. of this provider are reported on a	
FDRM CMS-2	567 (02-99) Previous Version	a Obsoleta Evant ID: JL9U11		Facility ID: 09G176	If continuation she	el Page 2 of 8

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

PRINTED: 09/07/2010 FORM APPROVED OMB NO, 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL			(X3) DATE SU COMPLE	
		09G178	B. WIN	G		08/27	7/2010
	ROVIDER OR SUPPLIER F WASHINGTON			130	ET ADDRESS, CITY, STATE, ZIP CODE 07 45TH PLACE, SE ASHINGTON, DC 20019		
(X4) ID PREFiX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFD TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 154	On August 26, 201 review of the facility investigations revea a. On August 22, 2 kitchen to the dinim head on the side of room. The client si eyebrow. Interview mental retardation 27, 2010, at approx that the potential so been investigated. b. On August 6, 20 from the day progra to the bathroom by his briefs down and right thigh. Intervie 27, 2010, at approx that he remembered show the surveyor occurred to Client a when asked if the i the QMRP stated to able to produce an Review of the facili- policy (IMC) on Aug 3:55 p.m., revealed investigated. Furth- that all serious repo- abuse/neglect and shall be investigated At the time of the s	0, beginning at 9:18 a.m., y's unusual incidents and aled the following: 010, while walking to the g table, Client #2 bumped h f the entrance to the living ustained an abrasion to his y with the facility's qualified profession (QMRP) on Aug kimately 3:31 p.m., revealed burce of the injury had not 10, Client #3 arrived home am and was escorted direct his 1:1 staff. The client pu d a bruise was observed on w with the QMRP on August kimately 3:45 p.m., revealed the incident and began to how the bruise may have #3's right thigh. However, incident had been investigat hat he believe so, but was r y documentation of it. ty's incident management gust 27, 2010, at approxima a all that all incidents are her review of the IMC reveal prable incidents including incidents of unknown origin red by the facility beginning er witnessed or discovered. urvey, there was no noce that the aforementioned	left just d tly illed the st d b ted, not led n	54	It is also the the Policy of this pro- that all of the incidents are reporte timely manner, and investigated. The QIDP did follow the incident protocol. The incident report was of on a timely manner, but the QIDP complete the investigation as stipu- incident management policy. Refer to attachment # 2 The QIDP was inserviced by the II Refer to attachment # In the future, the provider will ens- investigations are completed as sti- Incident Management Policy. The verify that all the incidents are inv- sent to the entities, and filed. b. It is also the the Policy of this p- that all of the incidents are reporte timely manner, and investigated. The QIDP did follow the incident protocol. The incident report was of on a timely manner, but the QIDP complete the investigation as stipu- incident management policy. This report was faxed to DOH on Refer to attachment # 2 The QIDP was inserviced by the II Refer to attachment # 2 In the future, the provider will ensu- investigations are completed as sti- Incident Management Policy. This report was faxed to DOH on Refer to attachment # 2 In the future, the provider will ensu- investigations are completed as sti- Incident Management Policy. The verify that all the incidents are inve- sent to the entities, and filed.	d on a managemen completed did not lated on the MC on ure that all pulated in th IMC will estigated, provider d on a managemen completed did not lated on the incident ViC on ure that all pulated in th IMC will	8-31-10 e 9-14-10 8-31-10

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 09G178

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

PRINTED:	09/07/2010
FORM /	APPROVED
OMB NO.	0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BU(I			(X3) DATE S COMPLE	
		09G178	B. WIN	IG		08/2	7/2010
	ROVIDER OR SUPPLIER			13(ET ADDRESS, CITY, STATE, ZIP CODE 07 46TH PLACE, SE ASHINGTON, DC 20019	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 156	CLIENTS The results of all in to the administrato or to other officials within five working This STANDARD Based on interview failed to report the the administrator w incident for one dis The finding include Review of an incide 2010 on August 26 a.m., revealed Clie injury above his lef #1's hospital "Disc! March 17, 2010, re included an abrasic Review of the corre dated March 17, 20 Qualified Mental Re (QMRP) completed 21, 2010. Further re	ent report dated March 17, 5, 2010, at approximately 9:30 int #1 sustained a physical t eyebrow. Review of Client harge Instructions" dated evealed the client's diagnoses on to the face. esponding investigative report 010, on August 26, 2010 at 5 a.m., revealed that the etardation Professional a the investigation on March eview revealed the	W 1	56	It is also the the Policy of this that all of the incidents are repo- timely manner, investigated. A investigation reports must be re- signed by the administration. The Incident Management Coo to have the investigation repor March 17, 2010 to be reviewed the administration. The IMC was inserviced by the on the investigation protocol o	rted on a Il of the viewed, and rdinator failed t dated I, and signed b Program Dire	хy
	investigative report Interview with the S 2010, at approxima acknowledged the and signed the inve	Supervisory LPN on August 26, ately 2:30 p.m., it was administrator had not reviewed			Refer to attachment #3 In the future, the Incident Mana Coordinator will ensure that all reports are signed, and reviewe administration.	of the investig	ative

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID; JL9U11

Facility ID: 09G178

If continuation sheet Page 4 of 8

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

PRINTED: 09/07/2010 FORM APPROVED OMB NO: 0938-0391

STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) N A. ĐƯ		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		09G178	BVW	4G _		08/2	7/2010
	ROVIDER OR SUPPLIER		•	13	LEET ADDRESS, CITY, STATE, ZIP CODE 307 45TH PLACE, SE VASHINGTON, DC 20019		
(X4) ID PREF3X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) Completion Date
W 156 W 159	of the survey the reported to the adm days of the inciden 483.430(a) QUALIF RETARDATION PI Each client's active	esults of all investigations was ninistrator within five working t. FIED MENTAL	w				
	This STANDARD Based on observat review, the facility f mental retardation coordinated, integr	ardation professional. is not met as evidenced by: ion, staff interview, and record ailed to ensure the qualified professional (QMRP) ated, and monitored services, lients residing in the sample.					
	dated July 6, 2010, approximately 10:0 been hospitalized v dehydration and rig Further review reve reduce the salt inta interview with the S 2010, at approxima acknowledged that was not made awar summary's recomm	I's hospital discharge summary on August 26, 2010, at 0 a.m., revealed Client #1 had with diagnoses that included with diagnoses that included with diagnoses tha			The hospital discharge recommen- change to Low Salt; The PCP was of this change, and agreed with the Client #1 had a follow-up visit w on 7-7-10. The PCP issued an ord change, and the change was imple- nurse did not place the POS on fit The nutritionist was made aware recommendations as well. Refer to attachment #. 5 In the future, the facility manager ensure that all records pertaining recommendations are placed on the	s made awar ne plan. ith the PCP der for the did emented, but ile. of the nent will to any	et the
W 331			W	331	records, and available upon reque		

FORM CMS-2567(02-99) Previous Versions Obsolete

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FacBity (D: 09G176

If continuation sheet Page 5 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2010 FORM APPROVED DMB ND: 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CU IDENTIFICATION NUMBER		ILTIPLE CONSTRUCTION	(X3) DATE S COMPL	
		09G178	B. WIN	3	08/2	27/2010
	ROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIF 1307 45TH PLACE, SE WASHINGTON, DC 20019	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETION DATE
W 331	services in accord This STANDARD	age 5 rovide.clients with nursing ance with their needs. is not met as evidenced b tion, interview and record	byr.	31		
	establish systems monitoring and ide with clients' needs facility. (Client # 1,	tility's nursing services fail to provide health care ntify services in accordan , for four of four clients in #2, #3 and Client # 4)	ice	Refer to W 130 P.1 of 8 Attachment #1.a Refer to W 455 P.7of 8		8-31-10
	staff failed to ensu protect the clients' medication admini 2. [Cross-refer to V	W130] The facility's nursi re an effective system to right for privacy during	ng	Attachment # 1.b		
W 356	an active program of infection for the	for the prevention and co	ntrol	56		
	treatment services needed for relief or	nsure comprehensive der that include dental care f pain and infections, n, and maintenance of der				
	Based on observat review, the facility received dental set	Is not met as evidenced b tion, interview, and record failed to ensure that client rvices in a timely manner, d clients. (Client #2)	ťs			

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: JL9U11

Facility ID: 09G178

if continuation sheet Page 6 of 8

		AND HUMAN SERVICES				FORM	09/07/2010 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL		E CONSTRUCTION	(X3) DATE S COMPLE	
		09G178	B. WIN	iG		08/2	7/2010
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
RCMO	WASHINGTON				7 45TH PLACE, SE SHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 356	Continued From pa	ige 6	W 3	356			
₩ 455	August 26, 2010, a #1 was observed to discoloration as he 1:1 staff and classr Review of Client #2 27, 2010, at approx dental consult date According to the co "heavy calculus de patient needs full in will submit pre-auth to reschedule once that the last docum dental treatment wa Interview with the fit Nurse (LPN) on Au approximately, 10:0 made several calls received a respons January 20, 2010. facility failed to ens dental services (ful 483.470(I)(1) INFE There must be an a prevention, control, and communicable This STANDARD if Based on observati	ucted at the day program on t 12:26 p.m., revealed Client o have missing teeth and some sat at the activity table with his nates. 2's medical record on August kimately 9:58 p.m., revealed a d January 20, 2010. Insult, the findings revealed posits" and recommended the nouth scaling with sedation horization to Medicaid will call returned. It should be noted ented time Client #2 received as on July 23, 2009. actility's Licensed Practical gust 27, 2010, at J5 a.m., revealed that she had to the dental office but had not e since Client #2's last visit on At the time of the survey, the ure Client #2 received timely I mouth scaling). CTION CONTROL active program for the and investigation of infection diseases. s not met as evidenced by: fon and interview, the facility active program for the	W 4	p a n so i d p t f c f c l n t f r n	Client #2's dental scaling was delay reauthorization for scaling was s nd was not received by dentist years envices to DCHRP nurse, who actor to continue to contact the dentist's ppointment, and document respond On 9-14-2010, the facility nurse of lentist office who stated that curre procedure to obtain scaling treatment the individual to have completed ollowing 1. Peridontal Probeing 2. Panoramic X-ray The dentist's will call to make the nace medicaid authorizes the scal in the future, the facility's nurse w he individuals dental care is provi- manner.	till pending, et. The facility is in dental livised the fac: office for nse. called the cently, the ent requires the appointment ing.	ility
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: Jt/9U11		Facility	y ID: 09G178 If ca	ntinuation she	etPage 7 of 8

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
		09G178	8. WINC	§	08/2	7/2010
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 1307 45TH PLACE, SE WASHINGTON, DC 20019	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 455	communicable dise residing at the hom The finding include On August 26, 201 Licensed Practical observed to use sa prior to mixing carr of milk for Client #2 the refrigerator doo then the rim of the cup to Client #2. During a face to fac August 26, 2010, a was acknowledged cup of milk when g touching the refrige counter.	eases, for one of four clients ie. (Client #2) s: 0, at approximately 6:30 a.m., Nurse #1 (LPN #1) was nitizer to cleanse her hands nation instant breakfast in a cup 2. However, LPN #1 touched or handle, cabinet counter and cup of milk prior to giving the ce interview with LPN #1 on t approximately 6:35 a.m., it she touched the rim of the fiving the cup to Client #2 after erator door handle and cabinet ence the facility's nursing staff program for the prevention and		As stipulated on the nursing must wash their hands befor medications, and the infection maintained through the enti- LPN #1 was inserviced by the Refer to attachment #1.b In the future, the med pass in the prevention of infection maintained during the entire administration process. The LPN should use the clear open the refrigerator She in by the middle or bottom to a to the rim.	re dispensing on control must be ire process. he DON on nurse will ensure that controlled is re medication an and dry towel to nust hold the cup/glas	

PRINTED: 09/07/2010

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM HFD03-0179		A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLET		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/27		
	WASHINGTON			H PLACE, SI ITON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD 8E	(X5) COMPLETE DATE	
	26, 2010 through a sampling of two repopulation of four mental retardation. The findings of the observations at the programs, intervie group home/day p clinical and admini incident/investigat. 3504.1 HOUSEKE The interior and e maintained in a sa and sanitary mannet.	y was conducted from a August 27, 2010. A ran esidents was selected f males with various lev and disabilities. The survey were based of e group home and two was with one family me program staff, and the r istrative records, includion reports. EEPING afe, clean, orderly, attra	rdom from a els of day mber, review of ding P shall be active,	1 000				
	This Statute is no Based on observa home for mentally failed to ensure th GHMRP was main attractive, and sar accumulations of to odors for four of fo (Clients #1, #2, #3) The findings include 1. The front entra concrete, which co hazard.	-	group IMRP) of the n, orderly, ree of stionable he facility. en		The broken concrete at front entra walkway is being repaired. In the future, the facility managen ensure that the front entrance wall good repair in order to prevent the The bricks in the front yard next to	nent will kway is in e trip hazard.	8-27-10	
atth Regul	ation Administration							
BORATOR					Aughorn Linorta	() () If continuation		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED 	
AME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
R C M O	WASHINGTON			H PLACE, S TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FÜLL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
1 090	 quality assurance a were left when the (The bricks were reconference that data Interior. 3. In the living room and peeling paint w 4. The carpet loca entering the bathroot tear in it which courhazard. 5. In the bathroom the first floor, the to have built up rus same bathroom was a ceiling was observed. These deficiencies QAA during this instant a 3509.6 PERSONN Each employee, prannually thereafter certification that a 1 performed and that a served a	at served no purpose. assistant (QAA) expla landscaping was chai emoved prior to the ex- ity). In behind the chair, ch was observed on the v ted on the hallway flow corn was observed to l ld be considered as a located near the bedr ollet safety guard was st on it. The vent loca as also observed with and #4's bedroom, the ed to have water stain a were acknowledged l spection.	ined they nged. kit ipping vall. or before have a trip rooms on observed ted in the rust. closet is. by the d cian ' s een lith status	1090	front porch were removed on In the future, the facility manage that the bricks in the front yard purpose are removed from the fit 3. The chipping and peeling pais chair in the living room were re In the future, the facility will en paintings on the walls show no 4. The tear on the carpet located floor before entering the bathroon In the future, the facility will en around the house is in good repa- tripping hazard. 5. The rusted toilet seat and ver In the future, the facility manage that all bathroom toilet seats and repair. 6. The ceiling in resident #3 and bathroom closet that had water seats for the future is the facility manage that had water seats for the future is the facility manage that had water seats for the future is the facility manage that had water seats and repair.	that serve no ront yard. nt behind the paired sure that all sign degradation I on the halfway om was repaired sure that the carj air, to prevent the nt were replaced ement will ensure d vents are in goo	9-1-10 9-2-10 9-2-10 e 9-2-10 e
	This Statute is not	met as evidenced by				Í	

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN DF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 08/27/2010 HFD03-0179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 45TH PLACE, SE **R C M OF WASHINGTON** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES 10 (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1206 1206 Continued From page 2 Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure that all employees had current health certificates, for two of the thirteen staff (Staff #1 and #3) and one of fourteen consultants. (Consultant #13) The finding includes: The health certificates for staffing #1 and #3 On August 27, 2010, beginning at approximately as wells as consultant #13 are currently on file. 9-9-10 3:45 p.m., review of the personnel records Refer to attachment #4 revealed the GHMRP failed to provide evidence that current health certificates were on file for two In the future, the HR department will ensure of fourteen staff (Staff #1 and #3) and two that all employees' files are up to date, and that consultants (Consultant #13) record are available upon request. The qualified mental retardation professional acknowledged the findings at approximately 4:30 p.m. 1226 1 226 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: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to ensure effective training on infection control, for one of four residents residing at the home. (Resident #2) The finding includes: On August 26, 2010, at approximately 6:30 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse her hands Health Regulation Administration STATE FORM JL9U11

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B WING 08/27/2010 HFD03-0179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 45TH PLACE, SE **R C M OF WASHINGTON** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1226 1226 Continued From page 3 As stipulated on the nursing policy, the nurses must wash their hands before dispensing prior to mixing carnation instant breakfast in a cup of milk for Resident #2. However, LPN #1 medications, and the infection control must be touched the refrigerator door handle, cabinet maintained through the entire process. counter and then the rim of the cup of milk prior LPN #1 was inserviced by the DON on 8-31-10 to giving the cup to Resident #2. Refer to attachment #1.b In the future, the med pass nurse will ensure that During a face to face interview with LPN #1 on August 26, 2010, at approximately 6:35 alm., it the prevention of infection controlled is was acknowledged she touched the rim of the maintained during the entire medication cup of milk when giving the cup to Resident #2 administration process. after touching the refrigerator door handle and It is the policy of this Provider that privacy cabinet counter. be provided during the medication There was no evidence the facility's nursing staff administration. provided an active program for the prevention To ensure privacy during the medication and control of infection. administration, each facility has a designated area where each individual is given the 1228 1228 3510.5(e) STAFF TRAINING medication out of the presence of the other individuals; however, the LPN who administered Each training program shall include, but not be the medication on August 26, 2010 at 6:30am limited to, the following: failed to provide privacy during the medication (e) Resident's rights; administration. The LPN who administered the medication was This Statute is not met as evidenced by: 8-31-10 inserviced by the DON on Based on observation and interview, the group Refer to attachment #1. home for mentally retarded persons (GHMRP) failed to ensure staff were effectively trained on In the future, the agency will ensure that the resident's rights to privacy for three of four nurses provide privacy during the medication residents living in the facility. (Residents #2, #3 administration. To prevent this situation to and #4) re-occur, the LPN supervisor will monitor the The finding includes: medication pass once monthly, and the RN supervisor will monitor the medication pass on a Observations during medication administration on quarterly basis as stipulated on the medication August 26, 2010, from 6:30 a.m. until 6:50 a.m. policy. Refer to the attached policy. revealed Licensed Practical Nurse #1 (LPN #1) administering Resident #2's medications in front of Client #1. Further observation revealed Resident #3 and Resident #4 being administered Health Regulation Administration

Health Regulation Administration

PRINTED: 09/07/2010

FORM APPROVED (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIA	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		HFD03-0179		B. WING		08/27	7/2010
	ROVIDER OR SUPPLIER		1307 451	DRESS, CITY, H PLACE, S TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE OATE
	During an interview 26, 2010, at approvided privation acknowledged that not provided privation administration. There was no evided during medication at 3519.10 EMERGE In addition to the re- each GHMRP shall Health, Health Fac- unusual incident or interferes with a re- arrangement, well places the resident be made by telephy followed up by writh	a front of Resident #2. with the LPN #1 on A dimately 6:55 a.m., it v Residents #2, #3 and y during medication ence that staff ensure administration.	August was d #4 was d privacy d privacy d privacy and privacy d pr	1 228	It is also the the Policy of this that all of the incidents are rep- timely manner, and investigate The QIDP did follow the incid protocol. The incident report w on a timely manner, but the QI complete the investigation as s incident management policy. T	orted on a cd, ent management vas completed DP did not stipulated on the	
	Based on interview home for mentally failed to ensure the Health Facilities Di notified, followed b hours, of unusual in interfered with a re	met as evidenced by and record review, the retarded persons (GH e Department of Healt vision was immediate y written notification was notidents that substant sident's health, for on ting in the facility. (Re	né group HMRP) th (DOH), ty vithin 24 tially re of the		report was faxed to DOH on Refer to attachment # The QIDP was inserviced by th Refer to attachment # In the future, the provider will investigations are completed a Incident Management Policy. verify that all the incidents are sent to the entities, and filed.	he IMC on ensure that all s stipulated in th The IMC will	9-14-10 8-31-1
	On August 26, 201	0, beginning at 9:18 a	a.m.				
atth Reou	ation Administration	o, boginning at o. 10 c]			<u> </u>

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Health Regulation Administration

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if continuation sheet 5 of 7

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Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUM	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2010	
NAME OF PROVIDER OR SUPPLIER STR				REET ADDRESS, CITY, STATE, ZIP CODE			00/2/12010	
	WASHINGTON		1307 45T	H PLACE, S	E			
	HASHING JOH		WASHING	STON, DC 2	20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) Complet Date	
1 379	Continued From page 5			1 379	It is also the the Policy of this pro	vider		
	review of the facility's unusual				that all of the incidents are reporte	dona		
	incidents/investigations revealed an incident		dent		timely manner, and investigated.			
	dated August 6, 2010. According the incident,				The OIDP did follow the incident	management		
	Resident #3 arrived home from the day program				protocol. The incident report was	-		
	and was escorted directly to the bathroom by his				on a timely manner, but the QIDP			
	1:1 staff. The client pulled his briefs down and a				complete the investigation as stipu			
	bruise was observed on the right thigh.				incident management policy. This			
	Interview with the qualified mentaly retardation				report was faxed to DOH on	mendent	9-14-10	
	professional (QMRP) on August 27, 2010, at				l .		3-14-10	
	approximately 3:45 p.m., revealed that he				Refer to attachment # 2		0.21.14	
	remembered the incident and began to show the				The QLDP was inserviced by the I	MCON	8-31-10	
	surveyor how the bruise may have occurred to				Refer to attachment # 2			
		gh. Further interview			In the future, the provider will ens			
	QMRP acknowledges that according to the incident report, DOH/HRLA had not been notified				investigations are completed as st		e	
	of the incident.				Incident Management Policy. The			
					verify that all the incidents are inv	estigated,		
J 401	3520.3 PROFESS PROVISIONS	ION SERVICES: GEN	IERAL	I 401	sent to the entities, and filed.			
	and evaluation, inc developmental lev services, and serv	ces shall include both cluding identification o els and needs, treatm ices designed to preve ther loss of function b	f ent ent					
	This Statute is not	t met as evidenced by	:		1			
	Based on interview and record review, the group							
	home for mentally retarded persons (GHMRP)							
		ofessional services we						
	provided in accordance with the needs of one of two sampled residents. (Resident #2)							
	The finding includes:							
i c	Observations cond	lucted at the day prog	ram on					
	August 26, 2010, at 12:26 p.m., revealed							
	Resident #1 was o	bserved to have miss	ing teeth					

Health Regulation Administration STATE FORM

		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM HFD03-0179		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2010			
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 45TH PLACE, SE WASHINGTON, DC 20019						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIÉNCIES MUST BE PRÉCEDED BY F SCIDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE		
	table with his 1:1 st Review of Resident August 27, 2010, af revealed a dental of 2010. According to revealed "heavy cal recommended the p scaling with sedatio pre-authorization to reschedule once re that the last docume received dental treat Interview with the G Nurse (LPN) on Aug approximately, 10:0 made several calls received a response on January 20, 2011 the GHMRP failed t	ation as he sat at the a aff and classmates. t #2's medical record of t approximately 9:58 p onsult dated January 2 o the consult, the findin loulus deposits" and patient needs full mou on will submit 0 Medicaid will call to turned. It should be n ented time Resident # atment was on July 23 6HMRP's Licensed Pra	on .im., 20, igs th oted 2 , 2009. actical she had t had not last visit urvey,	1401	Client #2's dental scaling was preauthorization for scaling wa and was not received by dentis nurse expressed concerns on d services to DCHRP nurse, whe to continue to contact the dent appointment, and document re On 9-14-2010, the facility nu dentist office who stated that of procedure to obtain scaling tre the individual to have comple following 1. Peridontal Probei 2. Panoramic X-ray The dentist's will call to make once medicaid authorizes the s in the future, the facility's nurs the individuals dental care is p manner.	as still pending, st yet. The facilit elays in dental o advised the fac ist's office for sponse. rse called the currently, the atment requires ted the ng the appointment scaling. se will ensure tha	r lity t		