

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

PRINTED: 01/24/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/17/2008
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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W 000	<p>INITIAL COMMENTS</p> <p>On January 15, 2008, the State agency received an e-mail from another governmental agency, forwarding an anonymous complaint received from an anonymous community member. The complainant said she had observed the group home residents scratching themselves while taking walks in the community. She thought they might have bed bugs in the facility. An onsite investigation was initiated on January 16, 2008, beginning at 3:49 PM. The facility provides supports and services for two women and four men with disabilities.</p> <p>The investigation findings were the result of interviews with clients, direct support staff and management, as well as inspection of the clients' bedrooms and review of the client's medical books, regarding dermatological care and treatments. Additional telephonic interviews were conducted the following day with the Qualified Mental Retardation Professional and the Registered Nurse.</p> <p>Based on observations, interviews and record review, the allegation of bed bug infestation was not substantiated. The investigation did, however, reveal incidental deficient practices, as outlined in the report that follows.</p>	W 000	<p>Although the allegation of bed bug infestation was not substantiated, please note that Westview Inc., is treated monthly for pest control by Orkin. A copy of the contract with Orkin and the invoice of its recent visit, at the time of the survey, were previously submitted for review by the staff at the Health and Regulation Administration, however, a copy of the most recent invoice and an additional copy of the contract with Orkin are attached for review with this Plan of Correction. (See Attachment #1 and 2)</p>	
W 116	<p>483.410(c)(6) CLIENT RECORDS</p> <p>The facility must provide each identified residential living unit with appropriate aspects of each client's record.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep available client records in the</p>	W 116		<p>RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 FEB -5 P 2:15</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul R West J MD</i>	TITLE <i>Administrator</i>	(X6) DATE <i>February 4 2008</i>
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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 116	<p>Continued From page 1</p> <p>facility, for one of the six clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>The complainant had indicated that she saw the clients scratching themselves while taking walks in the community. On January 16, 2007, at 4:02 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that two of the clients had been referred to a dermatologist in November and/or December 2007. At 5:11 PM, the QMRP said she would look downstairs for Client #4's medical record, since it was not on the shelf in the office. At approximately 7:04 PM, she indicated that the Registered Nurse had the book with her, out of the facility. At 7:12 PM, the RN confirmed by telephone with the QMRP that she had taken the client's chart with her when she left the previous evening. She took it for a review scheduled the next day with the primary care physician. Therefore, the record was not available for review before this surveyor left the facility at 7:24 PM.</p> <p>It should be noted that a nurse was in the facility administering medications to all clients, including Client #4, beginning at 6:14 PM. He completed the med pass and left the facility before 7:00 PM. In addition, the consulting nutritionist was also in the facility that evening to conduct her quarterly nutrition reviews.</p>	W 116	<p>Unless accompanied by the resident to a medical appointment, the QMRP will ensure that each resident's record is kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agency. Should the record need to be reviewed by the Primary Care Physician or any other member of the Interdisciplinary Team, he/she will be requested to come to the home to review the record. If an in-home record review is not feasible information needing to be reviewed will be duplicated and forwarded to the appropriate person in order for the resident's record and its contents to remain in the home. This practice will be maintained by the QMRP and the Nursing Coordinator with monitoring conducted by the Quality Assurance Coordinator.</p>	
W 339	<p>483.460(c)(4) NURSING SERVICES</p> <p>Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.</p>	W 339		

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W 339	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the Registered Nurse failed to include the most current diagnostic and treatment information on the Health Management Care Plan in the client's record, for one of the six clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>On January 16, 2008, at 4:02 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #1 had been to a dermatologist in November and/or December 2007. At 5:45 PM, review of Client #1's dermatology consultation sheets revealed that she had been seen by the dermatologist on November 15, 2007 and again on December 1, 2007. On December 1, 2007, the dermatologist diagnosed her with eczema, and prescribed two new medications [Hydroxyzine HCL 25 mg by mouth every evening; and Diflorasone 0.05% cream apply to affected areas twice daily].</p> <p>At 5:55 PM, review of Client #1's Health Management Care Plan (HMCP), dated December 31, 2007, revealed that it did not reflect the most recent information. The HMCP reflected the November 15, 2007 consultation, "no treatment indicated." It did not, however, indicate that she had returned to the dermatologist on December 1, 2007, and had a new diagnosis with new treatment orders (2 new medications were added).</p> <p>During a follow-up telephone interview with the RN on January 17, 2008, at approximately 1:15 PM, she stated that she had previously identified the need to further amend the client's HMCP and</p>	W 339	<p>The QMRP and the Nursing Coordinator will ensure that each resident's record is kept current, dated, and signed by each individual who makes an entry. The Nursing Coordinator amended the Health Care Management Care Plan for Resident #1 and included the most current dermatology diagnostic and treatment information. (See Attachment # 3) Should concerns arise that prevents a hard copy of updated information from being printed out, information will be handwritten and placed in the resident's record until printing concerns are resolved.</p>		

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W 339	Continued From page 3 had prepared one. She acknowledged, however, that the revised HMCP was not yet in the client's record (due to printer concerns).	W 339		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain Client #3's mattress in a clean and sanitary manner. The finding includes: On January 16, 2007, at 4:14 PM, Client #3's mattress, box spring and areas immediately next to his bed were inspected for evidence of bed bugs; no signs of infestation were noted. However, a strong urine odor was evidenced during the inspection. The Qualified Mental Retardation Professional acknowledged the foul odor and stated that she would have the staff sanitize and deodorize his mattress promptly. [Note: The client's mattress and box spring were both wrapped in plastic lining, due to his ongoing, diagnosed urinary incontinence.]	W 418	The QMRP immediately instructed the Evening Shift Supervisor to have one of the evening staff sanitize Resident #3's bed (plastic mattress covering) to eliminate the urine odor. The Night Shift Supervisor (s) was also instructed to ensure that the One to One Counselor(s) sanitize Resident #3's bed (plastic mattress covering), during the night, after each toileting incident. The housekeeping staff was also instructed to sanitize Resident #3's bed (plastic mattress covering) each morning. Each Shift Supervisor will monitor this practice on a daily basis with follow up monitoring conducted by the Residential Manager on a daily basis and the Quality Assurance Coordinator on a monthly basis.	

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1 000	<p>INITIAL COMMENTS</p> <p>On January 15, 2008, the State agency received an e-mail from another governmental agency, forwarding an anonymous complaint received from a community member. The complainant said she had observed the group home residents scratching themselves while taking walks in the community. She thought they might have bed bugs in the facility. An onsite investigation was initiated on January 16, 2008, beginning at 3:49 PM. The facility provides supports and services for two women and four men with disabilities.</p> <p>The investigation findings were the result of interviews with residents, direct support staff and management, as well as inspection of the residents' bedrooms and review of the resident's medical books, regarding dermatological care and treatments. Additional telephonic interviews were conducted the following day with the Qualified Mental Retardation Professional and the Registered Nurse.</p> <p>Based on observations, interviews and record review, the allegation of bed bug infestation was not substantiated. The investigation did, however, reveal incidental deficient practices, as outlined in the report that follows.</p>	1 000	<p>1000</p> <p>Although the allegation of bed bug infestation was not substantiated, please note that Westview Inc., is treated monthly for pest control by Orkin. A copy of the contract with Orkin and the invoice of its recent visit, at the time of the survey, were previously submitted for review by the staff at the Health and Regulation Administration, however, a copy of the most recent invoice and an additional copy of the contract with Orkin are attached for review with this Plan of Correction. (See Attachment #1 and 2)</p>	
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> <p>This Statute is not met as evidenced by: Based on observation and interview, the facility</p>	1 090		

Health Regulation Administration

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

STATE FORM

Brad R. West J. MD

Administrative

February 4, 2008

(X6) DATE

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I 090	Continued From page 1 failed to maintain Resident #3's mattress in a clean and sanitary manner. The finding includes: On January 16, 2007, at 4:14 PM, Resident #3's mattress, box spring and areas immediately next to his bed were inspected for evidence of bed bugs; no signs of infestation were noted. However, a strong urine odor was evidenced during the inspection. The Qualified Mental Retardation Professional acknowledged the foul odor and stated that she would have the staff sanitize and deodorize his mattress promptly. [Note: The resident's mattress and box spring were both wrapped in plastic lining, due to his ongoing, diagnosed urinary incontinence.]	I 090	1090 The QMRP immediately instructed the Evening Shift Supervisor to have one of the evening staff sanitize Resident #3's bed (plastic mattress covering) to eliminate the urine odor. The Night Shift Supervisor (s) was also instructed to ensure that the One to One Counselor(s) sanitize Resident #3's bed (plastic mattress covering), during the night, after each toileting incident. The housekeeping staff was also instructed to sanitize Resident #3's bed (plastic mattress covering) each morning. Each Shift Supervisor will monitor this practice on a daily basis with follow up monitoring conducted by the Residential Manager on a daily basis and the Quality Assurance Coordinator on a monthly basis.	
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to keep available resident records in the facility, for one of the six residents of the facility. (Resident #4) The finding includes: The complainant had indicated that she saw the residents scratching themselves while taking walks in the community. On January 16, 2007, at 4:02 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that two of the residents had been referred to a	I 261		

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I 261	Continued From page 2 dermatologist in November and/or December 2007. At 5:11 PM, the QMRP said she would look downstairs for Resident #4's medical record, since it was not on the shelf in the office. At approximately 7:04 PM, she indicated that the Registered Nurse had the book with her, out of the facility. At 7:12 PM, the RN confirmed by telephone with the QMRP that she had taken the resident's chart with her when she left the previous evening. She took it for a review scheduled the next day with the primary care physician. Therefore, the record was not available for review before this surveyor left the facility at 7:24 PM. It should be noted that a nurse was in the facility administering medications to all residents, including Resident #4, beginning at 6:14 PM. He completed the med pass and left the facility before 7:00 PM. In addition, the consulting nutritionist was also in the facility that evening to conduct her quarterly nutrition reviews.	I 261	1261 Unless accompanied by the resident to a medical appointment, the QMRP will ensure that each resident's record is kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agency. Should the record need to be reviewed by the Primary Care Physician or any other member of the Interdisciplinary Team, he/she will be requested to come to the home to review the record. If an in-home record review is not feasible information needing to be reviewed will be duplicated and forwarded to the appropriate person in order for the resident's record and its contents to remain in the home. This practice will be maintained by the QMRP and the Nursing Coordinator with monitoring conducted by the Quality Assurance Coordinator.	
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Registered Nurse failed to include the most current diagnostic and treatment information on the Health Management Care Plan in the resident's record, for one of the six residents of the facility. (Resident #1) The finding includes: On January 16, 2008, at 4:02 PM, the Qualified Mental Retardation Professional (QMRP)	I 291		

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I 291	<p>Continued From page 3</p> <p>indicated that Resident #1 had been to a dermatologist in November and/or December 2007. At 5:45 PM, review of Resident #1's dermatology consultation sheets revealed that she had been seen by the dermatologist on November 15, 2007 and again on December 1, 2007. On December 1, 2007, the dermatologist diagnosed her with eczema, and prescribed two new medications [Hydroxyzine HCL 25 mg by mouth every evening; and Diflorasone 0.05% cream apply to affected areas twice daily].</p> <p>At 5:55 PM, review of Resident #1's Health Management Care Plan (HMCP), dated December 31, 2007, revealed that it did not reflect the most recent information. The HMCP reflected the November 15, 2007 consultation, "no treatment indicated." It did not, however, indicate that she had returned to the dermatologist on December 1, 2007, and had a new diagnosis with new treatment orders (2 new medications were added).</p> <p>During a follow-up telephone interview with the RN on January 17, 2008, at approximately 1:15 PM, she stated that she had previously identified the need to further amend the resident's HMCP and had prepared one. She acknowledged, however, that the revised HMCP was not yet in the resident's record (due to printer concerns).</p>	I 291	<p>1291</p> <p>The QMRP and the Nursing Coordinator will ensure that each resident's record is kept current, dated, and signed by each individual who makes an entry. The Nursing Coordinator amended the Health Care Management Care Plan for Resident #1 and included the most current dermatology diagnostic and treatment information. (See Attachment # 3) Should concerns arise that prevents a hard copy of updated information from being printed out, information will be handwritten and placed in the resident's record until printing concerns are resolved.</p>	

**Westview Medical & Rehabilitation
Services, P.C., Inc.**

**3200 Twelfth Street, N.E.
Washington, D.C. 20017
westviewmed@msn.com
Phone: (202) 526-8222
Fax: (202) 832-2101**

Fred R. West, Jr., M.D., P.C.
Administrator

Christine Henderson
Residential Manager

FOUNDED 1988

February 4, 2008

Patricia W. VanBuren, Program Manager
Department of Health
Health Regulations and Licensing Administration
825 North Capital Street, NE – Second Floor
Washington, DC 20002

Dear Ms. VanBuren:

Enclosed please find the responses to the Statement of Deficiencies Report sent to us on January 24, 2008.

We want to thank your surveyor for his professionalism, during the monitoring visit to 3200 12th Street, NE.

If there are any questions regarding the Plan of Corrections, (POC) and the attached documents, please contact Vanessa Mitchell, Program Director, at (202) 526-8222 or (202)438-2246.

Sincerely,



Fred R. West, Jr. M.D.
Administrator

Enclosures

“For The Love Of Westview”