

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HPD12-0021	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(Q8) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER LT. JOSEPH P. KENNEDY INST OF CATHOLIC		STREET ADDRESS, CITY, STATE, ZIP CODE 4416 19TH ST, NE WASHINGTON, DC 20018		
(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)	(Q9) COMPLETE DATE
1000	INITIAL COMMENTS A licensure survey was conducted on November 12, 2010 through November 16, 2010. A random sample of three residents was selected from a resident population of five women with various disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including incident reports.	1000		
1229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with mental retardation (GHMRP) failed to ensure all staff received training on lifting and transferring for one of the three residents (Resident #2) included in the sample. The findings include: During the entrance interview on November 12, 2010, beginning at approximately 8:35 a.m., revealed the GHMRP had two Nursing Assistants from a local Home Care Agency (HCA) assigned to both Residents #1 and #2. Observation on November 16, 2010, at	1229	Tag 1229: Additional PT in-service training provided on 11/18/10 which included an agency staff mentioned in survey. Copy Attached. Review of the transfer Technique and evacuation plan covered As a part of training.	

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

STATE FORM



TITLE

Director

DATE

11/16/10

508 50M111

If continuation sheet 1 of 10

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I 229	Continued From page 1 approximately 10:45 a.m. revealed two staff, one of the nursing assistants and one of the GHMRP's direct care staff, assisting Resident #2 for toileting. The facility's staff was observed to use a gait belt around the waist of the resident. Further observation revealed the nursing assistant had some difficulty in assisting with the transferring of Resident #2 from her wheelchair to the toilet. The GHMRP's direct care staff was observed to place one hand on the back of the gait belt and her other hand on the front, however, the nursing assistant was observed to place her arm under the resident's arm to attempt to lift the resident. It should be noted that the bathroom was equipped with a grab bar located to the left of the toilet. Observation revealed the resident was able to assist, but needed to be verbally prompted. To prevent an incident, the surveyor verbally prompted the staff to prompt Resident #2 to grab a hold of the grab bar on the wall which did help the staff to successfully transfer the resident to the toilet. Review of the training records on November 15, 2010 at approximately 3:10 p.m., revealed "Transfer Training/Back Safety was scheduled on November 4, 2010 and again on November 11, 2010. Further review of the sign-in sheets for the aforementioned training revealed the GHMRP's direct care staff did not participate in either of the training dates offered. Additionally, it should be noted that the nursing assistant did not start working at the GHMRP until November 12, 2010. At the time of the survey, the GHMRP failed to ensure both the direct care staff and the HCA's nursing assistant was trained to lift and transfer Resident #2.	I 229		

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I 379	Continued From page 2	I 379		
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 review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for two of the three residents (Residents #1 and #2) included in the sample. The finding includes: 1. Review of the GHMRP's incident reports on November 12, 2010 beginning at 9:21 a.m., revealed Resident #1 was experiencing difficulty with walking on September 17, 2010. According to the report, the staff contacted the Director of Nursing (DON) who called 911. Review of the resident's medical record on November 12, 2010 at 3:53 p.m. revealed a document entitled "Nursing Health Wellness Assessment and Review of Delegated Care Event." The aforementioned document was dated September 17, 2010, and it revealed Resident #1	I 379		
			Tag I379: The Quality Assurance Department Will notify DOH on health and safety incidents That pose a health risk to all residents Located at 4419 19 th Street within 24 hours. The QA department has updated the fax Number to reflect reporting practices as Required. Date of Completion 12/13/10.	

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I 379	Continued From page 3 was admitted to the hospital on the CCU on the same date diagnosed with Myocardia Infarction. At the time of the survey, the facility failed to report this incident that substantially interfered with the resident's health and safety to the Department of Health (DOH) within 24 hours. It should noted that the incident was reported on September 21, 2010, four (4) days after the incident. 2. Review of the GHMRP's incident reports on November 12, 2010 beginning at 9:21 a.m., revealed Resident #2 was feeling weak on August 11, 2010. Arrangements was made for the resident to be taken to the emergency room. According to the report, the emergency room physician recommended that Resident #2 should be kept over night for further evaluation with a Cardiologist. Interview with the GHMRP's Quality Assurance Assistant (QAA) on November 15, 2010, at approximately 12:49 p.m. revealed that the QA department was responsible for submitting incident reports to the State Agency (Department of Health, DOH), and usually faxes the report. At the time of the survey, there was no documented evidence that the aforementioned incident that substantially interfered with the resident's health and safety was reported to the Department of Health (DOH) within 24 hours.	I 379		
I 412	3520.13 PROFESSION SERVICES: GENERAL PROVISIONS If a resident evidences the need for a professional service for which arrangements do not exist, the GHMRP shall have fourteen (14) days to show evidence of arrangements for	I 412		

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1412	<p>Continued From page 4</p> <p>provision of the professional service, except that in life threatening situations, arrangements must be made immediately.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure the provision of physical therapy services, for one of the three residents (Resident #1) included in the sample.</p> <p>The finding includes:</p> <p>a. Review of the GHMRP's incident reports on November 12, 2010 beginning at 9:21 a.m., revealed an incident report dated October 25, 2009 involving Resident #1. According to the report, Resident #1 was on her way to the bathroom, when she tripped on her jacket entering the bathroom.</p> <p>b. Review of an incident report dated April 25, 2010, on November 15, 2010, revealed Resident #1 was taken to the bathroom and placed on the toilet. According to the report, the staff left the resident to use the toilet and when the staff returned to the bathroom she found the resident sitting on the floor. The report also indicated that the resident had attempted to get up from the toilet and slipped and was found sitting on the floor.</p> <p>c. Another incident report dated July 15, 2010 involving Resident #1. According to the report, after Resident #1 completed her breakfast and she independently went into the living room. Continued review of the report revealed that when the staff went to check on the resident, the staff discovered that the resident was not in the living room, but found on the floor of her</p>	1412	<p>Tag 1412: Resident #1 has a history of falls Well documented over a long period of time. Her history of severe valvular and ischemic Heart disease with CHF (Congested Heart Failure) (not a candidate for surgical intervention) Has contributed to her propensity for falls. [REDACTED] also has had a very independent Nature that caused her to have behavioral issues If staff hovered over her too close. Balancing These factors contributed to staff allowing her Some time to move about the home without Constant supervision for no longer than 10 Minutes. The team discussed the approach Of keeping her safe which include a home Strengthening and balancing exercise program Monitored by the PT every 3 months. At this time, [REDACTED] has died as of 12/16/10 under hospice care.</p>	
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1412	<p>Continued From page 5</p> <p>bedroom. Further review of the incident report revealed the resident had a bruise on her forehead.</p> <p>c. Another incident involving Resident #1 was dated August 4, 2010. According to the incident report, the resident was found sitting on the floor and when asked by the staff what happened she reported that she had fallen trying to get her walker. Further review of the incident reports revealed on August 9, 2010, five (5) days later, Resident #1 was again found in the bathroom sitting on the floor. The report indicated that resident stated that she was trying to get her walker.</p> <p>Review of each of the aforementioned incidents revealed a section on the incident report form entitled "Action Taken" the following actions were revealed:</p> <p>October 25, 2009 incident - Staff assisted resident to her feet and checked for any signs of injury, then proceeded to contact the Director of Nursing (DON). Staff were instructed to inform the Medication Nurse to assess the resident when she/he arrived to the group home.</p> <p>July 15, 2010 incident - Supervisor checked Resident for any signs of injury and contacted the DON.</p> <p>April 25, 2010 incident - Staff instructed to call the nurse to come to the group home to assess the resident.</p> <p>August 4, 2010 incident - The resident's PCP was notified.</p> <p>Although the resident was evaluated by the</p>	1412		

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I 412	<p>Continued From page 6</p> <p>GHMRP's nursing department, there was no evidence that the resident was referred for evaluation regarding her falling.</p> <p>Record review and interview with the the Director of Nursing (DON) on November 15, 2010 at 9:56 a.m. revealed Resident #1 had been seen by a physical therapist. The resident's record verified a physical therapy assessment which was dated September 5, 2009.</p> <p>At the time of the survey, the GHMRP failed to ensure Resident #1 was reassessed to address the resident's falling.</p>	I 412		
I 999	<p>FINAL OBSERVATIONS</p> <p>This Provider is serving medically fragile residents. The following observations were made during the survey process:</p> <p>Upon entrance to the Group Home for Persons with Mental Retardation (GHMRP) on November 12, 2010, at approximately 8:25 a.m., it was observed that a warning sign for the use of oxygen was posted on the group home's front door. Further observation and interview with the House Manager revealed Residents #1 and #2 received oxygen. Additionally, interview with the House Manager, revealed both residents received a nurse's aide from a local Home Care Agency (HCA) for twelve (12) hours per day.</p> <p>Throughout the observations, Resident #1 was observed seated in a Geriatric chair in the living room, while Resident #2 was observed seated in her wheelchair, both receiving individual oxygen therapy, and their individual nurse's aides was observed seated next to them. It should be noted</p>	I 999	<p>Tag 1999: Resident #2 who has had a long standing History of severe debilitating health problems. Resident #2 has passed away as of 12/12/10 under The hospice services and the attendance of the RN of Kennedy Institute. She was receiving RN Services 24-hours per day when she died. Resident #2 started Hospice meds on 12/1/10 and Could not maintain her ability to swallow and take Oral meds and food, which is part of the dying Process on 12/5/10.</p> <p>Resident #1 who also has long standing non-Reversible medical issues is under Capital Hospice supervision. At this time, ██████████ Has died as of 12/16/10 under hospice care.</p>	

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I 999	Continued From page 7 on November 15, 2010 at approximately 3:03 p.m., another Geriatric chair was observed to be delivered to the home for Resident #2. Continued interview with the House Manager at approximately 8:38 a.m., revealed Resident #1 had experienced a heart attack and Resident #2 had experienced shortness of breath. At approximately 2:25 p.m., interview with the group home's Director of Nursing (DON) revealed Resident #1 was going to the day program up until she was admitted to the hospital on September 17, 2010. According to the DON, both Residents #1 and #2's families had signed "End of Life" documents. The DON revealed Resident #1 may have less than six (6) months to live and Resident #2 may have six (6) months to one (1) year to live. Review of Resident #1's medical record on November 12, 2010 at 3:53 p.m. revealed a document entitled "Nursing Health Wellness Assessment and Review of Delegated Care Event." The aforementioned document was dated September 17, 2010, and it revealed Resident #1 was admitted to CCU on the aforementioned date and diagnosed with a Myocardia Infarction. According to the resident's physician's orders dated October 2010, some of Resident #1's diagnosis included Interstitial Lung Disease, Neurogenic Bladder, and Hypertensive Cardiovascular Disease. Review of the "Client Plan of Care Information" (POC) dated November 5, 2010 revealed Resident #1 was independent until early in October when she was presented with weakness and inability to stand." The POC for Resident #1 also revealed after she suffered the Myocardial Infarction and developed Congestive Heart Failure, she was rehabilitated at a local nursing facility. Once the resident was discharged from the nursing facility, she needed	I 999		

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I 999	<p>Continued From page 8</p> <p>total care.</p> <p>Review of the GHMRP's incident reports on November 12, 2010 beginning at 9:21 a.m., revealed that Resident #2 was involved in an incident dated October 3, 2010. According to the report, the DON assessed the resident, took vitals and noted O2 saturation @80-82% before she was transported to the emergency room. Resident #2 was admitted to the Intensive Care Unit of the hospital and discharged on October 19, 2010.</p> <p>Resident #2's medical record was reviewed on November 15, 2010, beginning at approximately 1:43 p.m. A hospital discharge revealed the resident was "treated aggressively for congestive heart failure and bronchospasm".</p> <p>Interview with the DON and review of a request for "increase in Funding Needs for individuals at 19 th Street on November 15, 2010 revealed, the DON requesting emergency funding to "assist the dramatic change/need for additional staff to deliver intense services at the 19 th Street Home." Further review of the aforementioned document revealed Resident #2 spent approximately 2 1/2 weeks in the hospital and another twenty (20) days at a rehabilitation unit where she was recently discharged on November 8, 2010. According to the request, on the day of discharge, Resident #2 was unable to walk, stand or feed herself. She is 2-3 persons to assist her with bathing, transferring to her wheelchair, bed, or toilet.</p> <p>"The medical team and hospice experts have provided orders for special medications as both residents (Resident #1 and #2) condition deteriorates that must be administered every</p>	I 999		

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I 999	Continued From page 9 hour. Those medications are administered after an Registered Nurse (RN) assessment determines their condition has reached a certain level." It should be noted the group home also requested an RN in the home at all times. Continued review of the request revealed that the plans for Residents #1 and #2 "is to keep them in their home until the end arrives."	I 999			

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R 000	INITIAL COMMENTS Surveyor: 16663 A licensure survey was conducted on November 12, 2010 through November 16, 2010. A random sample of three residents was selected from a resident population five women with various disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Surveyor: 19326 Based on the review of personnel records and interview, the agency failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for two of the eleven (11) staff employed. (Staff #3 and #8) The findings include: On November 16, 2010, beginning at approximately 2:45 p.m., review of the personnel records revealed Direct Cara (Staff #3 and #8) had no documented evidence of a comprehensive criminal background check on file for review.	R 125	Tag R125: Staff #3 and #8 is not identified in Part of the statement of deficiencies. Kennedy institute is unable to ensure compliance in this Area and would need to identify the aforementioned Staff in question. Date of Completion 1/15/10.	

Health Regulation Administration

TITLE

(X6) DATE

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

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R 125	Continued From page 1 The house manager (HM), acknowledged the aforementioned findings at approximately 3:00 p.m. the same day.	R 125		
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