

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2011	
NAME OF PROVIDER OR SUPPLIER NATIONAL CHILDREN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6809 9TH ST, NW WASHINGTON, DC 20012		
(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	
1 000	INITIAL COMMENTS An annual licensure survey was conducted on July 13, 2011. A random sampling of three residents was selected from a population of five males with various levels of intellectual disabilities. The findings of the survey were based on observations at the group home, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	1 000	<p><i>Received 8/26/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: An observation on July 13, 2011, beginning at approximately 3:12 p.m., revealed the carpet in Residents #1 and #5's bedroom was heavily soiled. Additionally, Residents #2 and #4's bedroom carpet was observed with black splotches of dirt at the front of the egress. Interview with the Qualified Intellectual Developmental Professional, (QIDP) on the same day at approximately 3:20 p.m., revealed Resident #2 and #4's bedroom exit door is used by all the residents to board the van.	1 090		The carpet in the Aspen Home will be 9/1/2011 replaced in soiled and/or stained areas.
1 379	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	1 379		

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

STATE FORM

TITLE

(X6) DATE

Director of Residential Services 8/26/11

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If continuation sheet 1 of 2

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I 379	<p>Continued From page 1</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Individual Disabilities (GHPID) failed to ensure unusual incidents that interfered substantially with the resident's health were reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HLRA), for one of the residents residing in the facility. (Resident #5)</p> <p>The finding includes:</p> <p>Review of the GHPID's incident reports on July 13, 2011 beginning at approximately 10:31 a.m., revealed the direct care staff reported an incident involving Resident #5 dated October 29, 2010. According to the report, Resident #5 had become agitated and walked off from the direct care staff while they were in the store.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on July 13, 2011, at approximately 10:50 a.m. revealed the resident was missing from the facility for approximately three hours.</p> <p>At the time of the survey, there was no documented evidence that the aforementioned incident was reported to the Department of Health (DOH) within 24 hours.</p>	I 379	<p>Group Home for Persons with Intellectual Disabilities has a policy in place which dictates all Department of Health incidents will be reported within 24 hours. The incident Manager faxed the necessary information to DOH in a timely manner, but did not receive a confirmation page of his efforts. Group Home for Persons with Intellectual Disabilities now has a fax machine that will send out a confirmation page.</p> <p>9/1/2011</p>