

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7011 9TH ST, NW WASHINGTON, DC 20012</b>
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was initiated on January 6, 2011 through January 7, 2011. A sample of two residents was selected from a population of four females with various cognitive and intellectual disabilities.</p> <p>The findings of the survey were based on observations and interviews with staff in the home, nursing staff, as well as a review of resident and administrative records, including incident reports.</p>	1 000	<p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 800 North Capitol St., N.E. Washington, D.C. 20002</p> <p><b>RECEIVED</b> 1/24/11</p>	
1 090	<p><b>3504.1 HOUSEKEEPING</b></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 Group Home for Persons with Mental Retardation (GHMRP) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for four of the four residents in the facility. [Residents #1, #2, #3 and #4]</p> <p>The findings include:</p> <p>Observation and interview with the facility house manager (HM) on January 7, 2011, beginning at 4:20 p.m., revealed the following:</p> <p><b>Interior</b></p> <p>1. The light bulb located above the kitchen sink was observed to be burnt out. The same was</p>	1 090		

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*Michael W...*

TITLE *Program Director*

(X6) DATE *1/24/11*

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

STATE FORM

6899

DHD411

If continuation sheet 1 of 7

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1 090	Continued From page 1  observed with the light bulb located at the top of the basement steps.  2. The dryer knob on the dryer was observed to be broken. Resident #1 was observed to use pliers to turn the dryer knob to operate the dryer.  3. There was rust, dirt and rubbish observed around the hot/cold water knobs on Resident #1's bathroom sink.  Exterior  4. There was chipped and peeling paint on the ceiling of the front porch entrance.  5. There was an old rusted fence detached from its foundation lying on the side of the facility which could pose a trip hazard.  6. The lint trap outside the facility was observed with heavy build up of dirt and rubbish.  The HM acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	1 090	<u>INTERIOR:</u> ① light bulbs above kitchen sink and top of basement steps replaced. ② Dryer knob repaired. ③ Replaced knobs on Resident #1 bathroom sink. <u>EXTERIOR:</u> ④ Repair and paint front porch entrance. ⑤ Remove old fence. ⑥ Lint trap cleaned and added to weekly inspection by facility manager.  Additionally Facility Mgt. will complete a weekly facility check list to ensure safe and clean facility.	1/21/11 2/18/11 2/18/11 2/18/11 1/17/11
1 135	3505.5 FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for four of four residents residing in the facility. (Residents #1, #2, #3, and #4)	1 135		

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I 135	<p>Continued From page 2</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On January 6, 2011, at 2:15 p.m., interview with the house manager (HM) revealed that there were three designated shifts (8:00 AM -4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on the same day at approximately 2:23 p.m., revealed that no drills were held during the weekday morning shift from March 2010 through December 2010. In addition, there were no fire drills held during the weekend evening shifts from June 2010 through December 2010. This was acknowledged by the facility's HM on January 7, 2011, at 5:11 p.m.</p>	I 135	<p>QMPP will provide monthly oversight to ensure fire drills are done monthly on each shift, to include weekends.</p>
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation</p>	I 206	

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I 206	Continued From page 3  (GHMRP) failed to show evidence of a physician's certification that documented a health inventory had been performed, for one out of three trained medication employees (TME). (TME #1)  The finding includes:  On January 7, 2011, beginning at 4:05 p.m., review of the personnel records revealed no evidence of a current health certificate on file for TME #1. This was acknowledged by the qualified mental retardation professional (QMRP) on the same day at approximately 4:25 p.m.	I 206	Health Certificate for TME #1 is filed and available for review. 1/24/11
I 225	3510.5(b) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (b) Human development through the life cycle (birth to death);  This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure newly hired staff received training on Human development, for one of six staff. (Staff #5)  The finding includes:  On January 7, 2011, beginning at 3:40 p.m., interview with the house manager (HM), revealed that Staff #5 was newly hired (less than one month). Review of the staff training records on the same day at approximately 3:55 p.m. revealed that Staff #5 had not received any training on Human development. This was confirmed by the qualified mental retardation	I 225	The documentation for Human Development training for Staff #5 is in record and available for review. 1/24/11

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I 225	Continued From page 4 professional (QMRP) on the same day at approximately 4:00 p.m.	I 225		
I 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 staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure newly hired staff received training on infection control, for one of six staff. (Staff #5)  The finding includes:  On January 7, 2011, beginning at 3:40 p.m., interview with the house manager (HM), revealed that Staff #5 was newly hired (less than one month). Review of the staff training records on the same day at approximately 3:55 p.m. revealed that Staff #5 had not received any training on infection control. This was confirmed by the qualified mental retardation professional (QMRP) on the same day at approximately 4:00 p.m.	I 226	Documentation for universal precautions training for staff #5 is in the record and available for review.	1/24/11
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	I 379		

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I 379	<p>Continued From page 5</p> <p>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 GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for three of the four residents residing in the facility. (Resident #1, #2 and #3)</p> <p>The findings include:</p> <p>On January 6, 2011, at beginning at 1:06 p.m., review of the facility's incident reports revealed the following incidents were not reported as required:</p> <ol style="list-style-type: none"> <li>1. On April 6, 2010, Staff #1 was informed by Resident #2, that Staff #2 slapped her in the face. The facility did not have an internal investigation on hand at the time of the survey. However, review of the department on disabilities services (DDS) investigation on January 7, 2011, at approximately 3:15 p.m., substantiated the allegation of physical abuse to Resident #2.</li> <li>2. On April 19, 2010, Resident #1 complained of chest pains. The trained medication employee (TME) called the nurse's station and was informed by the nurse to call 911. While waiting for paramedics to arrive Resident #1 vomited. Upon arrival at 5:47 p.m., the paramedics checked the resident's vital signs and they were</li> </ol>	I 379	<p>#1 Please find attached our notifications requirements for all incidents. An Incident Management Coordinator will provide monthly oversight that all required notifications are made.</p> <p>#2 See tag # 1379.</p>	<p>1/24/11</p> <p>1/24/11</p>

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1379	<p>Continued From page 6</p> <p>normal. After Resident #1 refused to go to the emergency room for further evaluation, the facility's registered nurse (RN) came to the facility to assess the resident at her home on the same day at 7:10 p.m. Based on the RN's assessment, the resident was transported to the emergency room where she was admitted and discharged on April 20, 2010 with a diagnosis of chest pain, acute severe.</p> <p>3. On May 7, 2010, an allegation of neglect was made regarding Resident #1. Reportedly, Resident #1 had an outburst while at work (Target). According to the transportation manager, he/she arrived at the Target store at 4:55 p.m. and Resident #1 was standing out in front of the store alone. The resident's job coach who was assigned to the resident while at work could not be found.</p> <p>4. On September 5, 2010, Resident #3 was observed with a red spot under her right eye in the bottom of the right corner. The resident stated that she fell off the toilet and hit her eye on the door of the sink cabinet. The resident was taken to the emergency room and released on the same day with a diagnosis of hemorrhage - subconjunctival.</p> <p>On January 7, 2011, at approximately 3:30 p.m., interview with the incident management coordinator (IMC) and qualified mental retardation professional (QMRP) acknowledged that the Department of Health/Health Regulation and Licensure Administration (DOH/HRLA) was not notified of the aforementioned incidents according to the incident report documents.</p>	1379	<p>#3. See tag # 1379. 1/24/11</p> <p>#4. See tag # 1379. 1/24/11</p>