

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2010
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NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA	STREET ADDRESS, CITY, STATE, ZIP CODE 1786 VERBENA ST NW WASHINGTON, DC 20012
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1 000	INITIAL COMMENTS A licensure survey was conducted on August 18, 2010. A sampling of three residents from the residential population of five females was selected for the survey. The results of the survey was based on observations in the home, interviews with the administrative, nursing and direct care staff, as well as a review of the resident and administrative records and incident reports.	1 000		
1 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on staff interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure all staff were provided job descriptions as required by this section for two of the seventeen personnel records reviewed. (Staff #2 and #11) The findings include: Interview with the Residential Coordinator (RC) and review of the personnel records on August 18, 2010, beginning at approximately 2:33 p.m., revealed no documented evidence of job descriptions for two direct care staff. At the time of the survey, there was no documented evidence of written job descriptions for two employees to outline duties and supervisory controls, as required by this section.	1 202	3509.2 Personnel Policies: 1202-The provider will ensure that each employee's job description is signed upon hire. In addition, employee job descriptions will be signed annually during the employee evaluation. Quality Assurance reviews will be conducted by the Director of Operations or designee bi-annually and documented on the respective quality assurance tool.	8/25/10 10/18/10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
225 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
9.20-10

Health Regulation Administration <i>Luis J. Lopez-Clark</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Mugham Director	(X6) DATE 9/20/10
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1206	Continued From page 1	1206		
1206	<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 staff interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure all staff received an annual health inventory prior to employment as required by this section for seven of the seventeen currently employed staff. (Staff #1, #3, #6, #9, #15, #16, and #17)</p> <p>The findings include:</p> <p>Interview with the GHMRP's Residential Coordinator (RC) and review of the facility's personnel records on August 18, 2010 beginning at approximately 2:33 p.m., revealed seven employees failed to evidence an health inventory.</p> <p>At the time of the survey, the GHMRP failed to ensure evidence that all staff including had secured the proper and necessary health screening as required by this section.</p>	1206	<p>3509.6 Personnel Policies:</p> <p>1206-Upon hire, all new employees will be required to furnish evidence of health screening. The health screening should be dated within the current year of hire.</p> <p>Going forward, all new hires and current employees will be required to have their health screenings on a standard Health Certification form supplied by Volunteers of America Chesapeake, Inc</p>	10/18/10 10/18/10
1291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p>	1291		

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1291	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on review of records and interviews, the Group Home for Mentally Retarded Persons (GHMRP) staff failed to sign all entries made in two (2) of three (3) resident's records. (Residents #1 and #3)</p> <p>The findings include:</p> <p>1. On August 18, 2010, a record review of Resident #1's record at approximately 11:25 am revealed a nursing self-medication assessment dated June 30, 2010. There was no documented evidence of a nurse's signature on the aforementioned document.</p> <p>During a face to face interview with the Nurse Coordinator on August 18, 2010 at approximately 11:35 a.m., the finding was acknowledged.</p> <p>2. On August 18, 2010, a record review Resident #3's record at approximately 2:15 p.m. revealed a nursing self-medication assessment dated June 30, 2010. There was no documented evidence of a nurse's signature on the document.</p> <p>During a face to face interview with the Nurse Coordinator on August 18, 2010 at approximately 2:35 p.m., the finding was acknowledged.</p>	1291	<p>3514.2 Resident Records</p> <p>1291-The provider acknowledges that a manual signature is required on the self-medication assessment. Going forward the provider will ensure that the RN manually signs all self-medication assessment.</p> <p>Quality Assurance reviews will be conducted by the Director of Operations or designee bi-annually and documented on the respective quality assurance tool.</p>	9/1/10 10/18/10
1370	<p>3519.1 EMERGENCIES</p> <p>Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for mentally Retarded Persons (GHMRP)</p>	1370		

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I 370	<p>Continued From page 3</p> <p>failed to ensure their Incident Management policy included to contact the Department of Health (DOH), Health Regulation Administration, (HRA) for one of the three residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on August 18, 2010, beginning at approximately 2:33 p.m. revealed the following:</p> <p>On August 3, 2010, at 8:46 a.m., the direct care staff reported that Resident #4 pushed Resident #2, and in the process Resident #2 "fell and hit her head on the wood floor." The resident was taken to the Emergency Room and diagnosed with a head injury.</p> <p>Interview with the Residential Coordinator (RC) on August 18, 2010, at approximately 11:33 a.m. revealed that she was also the facility's Incident Management Coordinator (IMC). Continued interview with the (IMC) revealed that it was her responsibility to contact case manager, the resident's guardian, the department of health (DOH), the program director, and the vice president.</p> <p>Review of the facility's Incident Management policy on August 18, 2010 at approximately 2:10 p.m., revealed the facility's policy recommended that their direct care staff should not contact DOH, however, the policy failed to indicate the responsibility of what personnel should make that contact.</p> <p>At the time of the survey, the facility failed to ensure their IM policy included notifying the state agency, Department of Health (DOH), Health</p>	I 370	<p>3519.1 Emergencies 1370-The current incident management policy will be revised to include notification of the DOH in all incidents that substantially affects the health and safety of residents. The notification will made by the Incident Management Coordinator or designee within 24 hours of discovery.</p>	9/1/10

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1370	Continued From page 4 Regulation Administration, (HRA) of incidents that substantially affects the health and safety for Resident #2.	1370		
1379	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, (HRA) for one of the three residents (Resident #2) included in the sample. The finding includes: Review of the facility's incident reports on August 18, 2010, beginning at approximately 2:33 p.m. revealed the following: On August 3, 2010, at 6:46 a.m., the direct care staff reported that Resident #4 pushed Resident #2, and in the process Resident #2 "fell and hit her head on the wood floor." The resident was taken to the Emergency Room and diagnosed	1379	3519.10 Emergencies 1379-Going forward notification of all incidents that substantially affects the health and safety of residents, will be made by the Incident Management Coordinator or designee within 24 hours of discovery.	9/1/10

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1406	<p>Continued From page 6</p> <p>Resident #1 was prescribed psychotropic medication. Review of the medical record on the aforementioned date at 11:25 a.m. revealed a physicians' order (PO) dated August 2010. According to the PO, the resident was prescribed Buspar, Tegretol and Risperdal.</p> <p>Review of Resident #1's Individual Habilitation record on August 18, 2010 at approximately 1:42 p.m. revealed no documented evidence of a Behavior Support Plan. Interview with the Program Director on August 18, 2010, at 12:39 p.m. revealed the resident had been seen by the psychologist on August 17, 2010. At the time of the survey, there was no documented evidence of services provided by a psychologist for Resident 1.</p> <p>2. During the entrance conference conducted on August 18, 2010, at approximately 11:15 a.m., interview with the Program Director revealed Resident #2 was prescribed psychotropic medication. Review of the medical record on the aforementioned date at 1:40 p.m. revealed a physicians' order (PO) dated August 2010. According to the PO, the resident was prescribed Risperdal.</p> <p>Review of Resident #2's Individual Habilitation record on August 18, 2010 at approximately 12:34 p.m. revealed no documented evidence of a Behavior Support Plan. Interview with the Program Director on August 18, 2010, at 12:39 p.m. revealed the resident had been seen by the psychologist on August 17, 2010. At the time of the survey, there was no documented evidence of services provided by a was no documented evidence of services provided by a psychologist for Resident #2.</p>	1406	<p>3520.8 Professional Services; General Provisions</p> <p>Response to 1 and 2 1406-The provider will ensure that all professional services staff will sign in (upon entering the home/facility). Evidence of the professional service visits will be documented in the progress notes and/or the medical consultation form.</p>	9/24/10

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1379	Continued From page 5 with a head injury. Interview with the facility's Residential Coordinator/Incident Management Coordinator (RC/IMC) on August 18, 2010 at approximately 11:33 a.m. revealed the incident was reported to the mental retardation consumer information (MCIS). Further interview with the GHMRP's RC/IMC on August 18, 2010, at approximately 11:33 a.m., was conducted to ascertain information regarding the facility's Incident Management protocol. According to the RC/IMC, in the event of an incident, the direct care staff should file an incident report and contact the following individuals: RC, the GHMRP's nurse, the program director, and the qualified mental retardation professional (QMRP). 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.	1379		
1406	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provided shall be documented in each resident's record. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each professional service provided was documented in each resident's record. (Resident #2) The finding includes: 1. During the entrance conference conducted on August 18, 2010, at approximately 11:15 a.m., interview with the Program Director revealed	1406		

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I 435	Continued From page 7	I 436		
I 436	<p>3521.7(f) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);</p> <p>This Statute is not met as evidenced by: Based on review of records and interviews, the Group Home for Mentally Retarded Persons (GHMRP) failed to develop a self-medication training program, for two of the two residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>1. On August 18, 2010, a record review of Resident #1's record at approximately 11:25 am revealed a nursing self-medication assessment dated June 30, 2010, which indicated that resident could self-medicate, however there was no documented evidence of a self-medication training program in the resident's record.</p> <p>During a face to face interview with the Nurse Coordinator on August 18, 2010, at approximately 11:35 a.m., the finding was acknowledged.</p> <p>2. On August 18, 2010, a record review of resident #3's record at approximately 2:15 p.m. revealed a nursing self-medication assessment dated June 30, 2010, which indicated that the resident could self-medicate, however, there was no documented evidence of a self-medication training program in the resident's record.</p>	I 436	<p>3521.7 (f) Habilitation and Training</p> <p>1436-Residents 1 and 3 have been re-assessed for self medication training. It has been determined that self-medication training is not appropriate for these individuals at this time. If it is determined that an individual is a candidate for self-medication training the following will occur:</p> <ol style="list-style-type: none"> 1) Case conference to discuss candidacy or discussion at the ISP (whichever can occur sooner) 2) Formal goals developed to include in the ISP 3) Documentation of the discussion will be included in the appropriate section in the ISP and/or in nursing notes. 	9/24/10

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I 436	Continued From page 8 During a face to face interview with the Nurse Coordinator on August 18, 2010 at approximately 2:35 p.m., the finding was acknowledged.	I 436		