

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

PRINTED: 07/11/2008
FORM APPROVED
CMS NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
| NAME OF PROVIDER OR SUPPLIER D O HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 909 14TH STREET, SE WASHINGTON, DC 20019 | | |
| (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) COMPLETION DATE |
| W 000 | INITIAL COMMENTS This recertification survey was conducted from June 4, 2008 through June 6, 2008. The survey was initiated as a fundamental survey, however due to deficient practices the survey process was extended in the Conditions of Client Protection, Active Treatment and Health Care Services. A random sampling of three clients was selected from the residential population of six females with varying degrees of disabilities. A random sample of three clients was selected from a population of six males with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports. The results of this survey revealed that the facility was not in compliance with the Conditions of Client Protection. | W 000 | <p><i>Received on 7/14/08</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> | |
| W 104 | 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility's nurse failed to properly destroy medications for three of three clients residing in the facility. (Clients #3, #4 and #6) The finding includes: 1. On June 4, 2008 at 7:40 AM, the medication | W 104 | | |

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

Gony Stephen

TITLE

President

DATE

7-11-08

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.

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

PRINTED: 06/24/20
FORM APPROVAL
OMB NO. 0938-031

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 |
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| W 104 | <p>Continued From page 1</p> <p>nurse was observed preparing the client medications. While preparing Client #3's medication, the nurse dropped one Aspirin pill on the floor and two Senna Gen tablets on the counter top. At 7:45 AM, the medication nurse was observed throwing the pills in the kitchen trash can. At 7:58 AM, the medication nurse was observed dropping Client #6's two Senna Gen pills on the counter top. Minutes later she was observed throwing the pills in the kitchen trash can. At 8:20 PM, the medication nurse dropped Client #4's Prisoletc pill on the floor. And was later observed throwing the pill in the kitchen trash can.</p> <p>Interview with the medication nurse at approximately 8:30 AM revealed the policy stated, "the pills can be thrown in the trash." Review of the policy manual on June 4, 2008 at approximately 1:30 PM revealed a medication destroying policy. The policy indicated the following procedures:</p> <ul style="list-style-type: none"> - the medications can be destroyed in the facility; - have two witnesses present (licensed nurse, program directors, pharmacist or staff); - flush medication in the toilet; - have witnesses sign a destroying medication form; - notify nurse in charge; and - replacement order must be placed within 24 hours. <p>2. The governing body failed to ensure facility's</p> | W 104 | <p>An in service training was given to nurses on 06/05/08 and 07/01/08 about dispensing medication and discarding medication. Also nurses were trained to follow all regulations from DCHC policy and procedure. Nurse-in-charge will monitor on weekly basis initially and then on monthly basis to ensure above.</p> <p>See Attachment A</p> | 06/05/08 and 07/01/08 |

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

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OMB NO. 0938-03

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| W 104 | Continued From page 2 were free from mice. On June 4, 2008 at 1:55 PM a mouse was observed to walk across the kitchen counter to the stove. The mouse walked from burner to burner and then disappeared into the stove. The nurse was present when the mouse was observed. Attempts were made to locate the mouse, however were unsuccessful. Small black specs was observed on the floor between the kitchen wall and the stove. Interview with the House Manger revealed that she had not observed any mice in the facility. Review of the facility's records revealed that the pest control contractor had last treated the facility for mice on February 5, 2008. The QMRP indicated that the pest control contractor would be contacted about the mouse. | W 104 | The pest control contractor serviced the facility on 06/06/08. The QMRP will ensure that the environment is kept neat and tidy and pest control services will be maintained on a monthly basis. Please See Attachment D | 06/06/08 |
| W 120 | 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of one of the three clients included in the sample. (Client #3) The findings include: 1. The facility failed to elevate Client #3's leg while at the day program. On June 4, 2008 at 11:15 AM Client #3 was observed at his day program. The client was sitting in a chair with his feet on the floor watching | W 120 | The QMRP retrained the day program staff on how to encourage client #3 to keep his legs elevated on 06/30/08. The QMRP will make monthly visit to ensure that the needs of clients #3 are met. QMRP had supplied the day program a stool on 01/08/08 for client #3 to elevate his legs. Please See Attachment C. | 06/30/08 |

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W 120 Continued From page 3
televis on in a room with his peers. Review of the clients record on the same day at approximately 3:30 PM revealed a Protocol for TED Hose effective January 1, 2008 that reflected the clients feet should be elevated day, evening and night. The day program observation was brought to the attention of the house manager and the Qualified Mental Retardation Professional (QMRP) on June 5, 2008 at approximately 12:00 PM. They acknowledged the clients feet should have been elevated while the client was sitting in the chair at the day program.

2. The day program failed to notify the facility of an incident in which Client #3 sustained an injury.

Review of Client #3's day program records on June 4, 2008 at approximately 11:30 AM revealed a nursing note dated July 17, 2007. The note indicates that the client sustained an injury to his right knee after he fell while on an outing. The injury was described as an abrasion with skin peeling away, no bleeding or swelling. Interview with the day program's nurse on the same day at approximately 12:35 PM revealed that there had been no injuries to her knowledge. Interview with the QMRP on June 5, 2008 at approximately 2:00 PM revealed that he had no knowledge of the incident.

W 122 483.42c CLIENT PROTECTIONS
The facility must ensure that specific client protections requirements are met.

This CCNDITION is not met as evidenced by: The the facility's nurse failed to properly destroy medications [W104]; facility's nurse failed to

W 120

W120
2.

W 122

The QMRP initiated an investigation with the day Program nurse on 06/05/08. The nurse indicated that she inadvertently forgot to notify the Home about the injury of client #3.

On 06/30/08 the QMRP met with the program manager, the LPN and RN of NCC day program to address the need for proper communication from both sides. It was agreed that, effective immediately the day program will notify the QMRP by phone and letter of any incidents. The QMRP will ensure that the day program maintain good communication with the home and report injuries immediately.

Please See Attachment C.

06/05/08

06/30/08

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| W 122 | Continued From page 4 protect the clients' right to privacy during administration of medications [W130]; facility failed to implement clients feeding protocols to ensure the client's health and safety, for two of the three clients residing in the facility [W149]; and the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to District law [W153]. | W 122 | | | |
| W 124 | The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being. 483.421(e)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by. Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the three clients included in the sample. (Client #2) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on June 4, 2008 at 9:20 AM | W 124 | The QMRP made several attempts to reach client #2 legal guardian by phone in order to get consent for client #2 psychotropic medication. However the guardian was traveling and could not be reached. QMRP will ensure that in future all consent are signed by guardian in a timely manner prior to administering any psychotropic medication. Please See Attached Consent for Client #2 | | |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 801 14TH STREET, SE WASHINGTON, DC 20019 |
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| W 124 | <p>Continued From page 5</p> <p>during the entrance conference indicated that Client #2 receives psychotropic medication for his maladaptive behaviors. Review of the client's current physician orders revealed that the client also received Seroquel 25 mg and Buspar 5 mg in the evening. Further record review revealed that the Seroquel was ordered and implemented on March 17, 2008. According to the medication administration record on June 4, 2008 at 6:00 PM indicated that the medication was administered on the morning of March 18, 2008. Further record verification indicated that the medication was incorporated into the client Behavior Support Plan (ESP) dated February 9, 2008 to address targeted behaviors that included verbal aggression and physical aggression.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on June 6, 2008 at approximately 9:30 AM revealed that Client #2 had a court appointed guardian. Review of the client Psychological assessment dated June 26, 2007, at approximately 1:21 PM revealed that the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's guardian prior to the implementation of the Seroquel of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP.</p> | W 124 | | |
| W 130 | <p>483.421(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> | W 130 | | |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 503 14TH STREET, SE WASHINGTON, DC 20018 | | |
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| W 130 | Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's nurse failed to protect the clients' right to privacy during administration of medications for five of six clients residing the facility. (Clients #1, #3, #4, #5 and #6) The finding includes: The morning medication pass was observed on June 4, 2008 from 7:40 AM to 8:20 AM. The clients were seated at the dining room table eating their breakfast. The nurse administered each of their medications while they sat at the table with staff. During an interview with the nurse on the same day, she acknowledged the lack of privacy was brought to her attention. | W 130 | On 06/09/08 the DON and QMRP retrained the medication nurses (LPN's) on the protocol in the administration of medication to all individuals with emphasis on privacy issues and self medication programs. Please See Attachment A. | 06/09/08 | |
| W 149 | 483.42(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement feeding protocols to ensure clients' health and safety, for two of the three clients residing in the facility. (Clients: #3 and #5) The findings include: 1. During dinner observations on June 4, 2008 at | W 149 | | | |

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| W 149 | <p>Continued From page 7</p> <p>8:40 PM, Client #5 was observed sitting in a regular chair being fed a pursed textured diet from an elevated plate stand. The client was observed coughing during dinner. The staff immediately stopped feeding him. At 8:49 PM, direct care staff was observed pouring two scoops of "Thick-It" into a cup of milk. Minutes later, the client was observed drinking the milk with the added thickener independently. However, there was no noticeable change in the milk texture. At 8:55 PM, the direct care staff was interviewed to ascertain the texture of the liquid. The direct care staff could not recall the client's prescribed liquid texture.</p> <p>At 7:05 PM the House Manager was interview about the dinner observation, the House Manager indicated that the client's liquid was required to be served in honey consistency. The direct care was immediately inserviced by the House Manger on the client's liquid texture dietary order.</p> <p>On June 5, 2008 Client #5's feeding protocol dated October 18, 2007 was reviewed and reflected the following guidelines/procedures:</p> <ul style="list-style-type: none"> - Provide liquids in honey consistency; - Provide headrest for stability to avoid hyper-extension of head during swallowing; and - Sit upright for 30-45 minutes after the meal. <p>There was no evidence that the facility implemented the above protocol.</p> <p>2. Observations during the breakfast on June 4, 2008 at 7:15 AM, Client #3's was observed eating</p> | W 149 | <p>The staff was retrained on 06/30/08 by the nutritionist on the dietary orders and feeding protocols for all individuals. QMRP will administer monthly test to staff to ensure that all staff are knowledgeable and able to implement the dietary orders and also will check meal times unannounced to make sure staff is following all outlined protocols. QMRP will monitor meal time daily for two weeks, then monthly and at unannounced periods.</p> <p>Please See Attachment D.</p> | 06/30/08 |
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| W 149 | Continued From page 8 a chopped meal. At 7:40 AM, the client was observed during medication administration. The nurse prepared the medication, and poured the water. One pill (oyster shell with vitamin D) was noted to be a large green pill which the nurse spoon fed the client separately. The client drank four eight ounce cups of water (32 oz) to aid in swallowing the pill. Interview with the nurse on the same day revealed that the client had difficulty swallowing pills. Review of the clients medication record revealed that he had a diet order for all foods to be chopped. Interview with the nurse revealed that some of the clients medications could not be crushed to facilitate safe swallowing. When asked if the Primary Care Physician (PCP) was made aware that the client had problems swallowing the pills so that an alternative form could be considered; she indicated that the PCP had not been consulted. | W 149 | The primary care physician was contacted about Oyster Shell pill which client has problem in swallowing. After discussing with Pharmacist FMD ordered to crush above tablet. Nurses were told of above and follow the order. Nurse-in-charge will monitor to make sure above is followed properly, on a weekly basis. Please See Attachment A 3. | 06/05/08 |
| W 153 | 483.42)(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 36, Section 3519.10) one of the three clients included in the sample. (Client #3) | W 153 | | |

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NAME OF PROVIDER OR SUPPLIER

D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
903 14TH STREET, SE
WASHINGTON, DC 20018

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W 153

Continued From page 9
The finding includes:
The day program failed to notify the facility of an incident in which Client #3 sustained an injury.
Review of Client #3's day program records on June 4, 2008 at approximately 11:30 AM revealed a nursing note dated July 17, 2007. The note indicated that the client sustained an injury to his right knee after he fell while on an outing. The injury was described as, "an abrasion with skin peeling away, no bleeding or swelling." Interview with the day program's nurse on the same day at approximately 12:35 PM revealed that there had been no injuries to her knowledge. Interview with the Qualified Mental Retardation Professional (QMRP) on June 5, 2008 at approximately 2:00 PM revealed that he had no knowledge of the incident.

W 153

The QMRP initiated an investigation with the day Program nurse on 06/05/08. The nurse indicated that she inadvertently forgot to notify the Home about the injury of client #3.

6-5

On 06/30/08 the QMRP met with the program manager, the LPN and RN of [redacted] to address the need for proper communication from both sides. It was agreed that, effective immediately the day program will notify the QMRP by phone and letter of any incidents. The QMRP will ensure that the day program maintain good communication with the home and report injuries immediately.

W 159

483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL
Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.
This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's Qualified Mental Retardation Professional (QMRP) failed to coordinate the care of the clients in the facility for one of the two clients in the sample. (Client #2)

W 159

The findings include:
The facility failed to ensure that Client #2 received his prescribed diet at both day program and home.

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| W 159 | Continued From page 10 Observations at Client #2's day program on June 4, 2008 at 12:35 PM, the client was observed eating his lunch. The meal consisted of meatballs, noodles, okra with tomatoes, bread, applesauce, and 1% chocolate milk. At 1:05 PM, the client completed his meal and walked to his treatment room. During dinner observations at 6:40 PM, Client #2 was observed eating sliced turkey, mashed potatoes, cabbage, bread and fruit cocktail. Review of Client #2's current physician orders on June 5, 2008 at 10:00 AM revealed the client was prescribed 1500 calorie diet with extra salad. Interview with the direct care staff who prepared the meal, indicated that she forgot to prepare the salad for Client #2. | W 159 | QMRP contacted case manager at [redacted] on 06/19/08 and discussed about client #2's dietary order. On 07/01/08 met with direct care staff at [redacted] and gave an in service training. QMRP will visit day program on weekly basis to ensure that the above is followed properly, for a month and then monitored monthly. <i>See attachment D2</i> | 6-19-08 7-1-08 |
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| W 194 | 483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to demonstrate competency in implementing clients feeding protocols for one of the six clients in the facility. (Client: #5) The finding include: During dinner observations on June 4, 2008 at 6:40 PM, Client #5 was observed sitting in a regular chair being fed a pureed textured diet from an elevated plate stand. The client was | W 194 | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D0G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/06/2008 |
|---|--|--|---|--------------------|--|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 902 14TH STREET, SE WASHINGTON, DC 20019 | | |
| (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 | |
| W 194 | <p>Continued From page 11</p> <p>observed coughing during dinner. The staff immediately stopped feeding him. At 8:49 PM, direct care staff was observed pouring two scoops of "Thick-It" into a cup of milk. Minutes later, the client was observed drinking the milk with the added thickener independently. However, there was no noticeable change in the milk texture. At 8:56 PM, the direct care staff was interviewed to ascertain the texture of the liquid. The direct care staff could not recall the client's prescribed liquid texture.</p> <p>At 7:05 PM the House Manager was interview about the dinner observation, the House Manager indicated that the client's liquid was required to be served in honey consistency. The direct care was immediately inserviced by the House Manger on the client's liquid texture dietary order.</p> <p>On June 5, 2008 Client #5's feeding protocol dated October 18, 2007 was reviewed and reflected the following guidelines/procedures:</p> <ul style="list-style-type: none"> - Provide liquids in honey consistency; - Provide headrest for stability to avoid hyper-extension of head during swallowing; and - Sit upright for 30-45 minutes after the meal. <p>There was no evidence that the facility implemented the above protocol.</p> | W 194 | <p>The staff was retrained on 06/30/08 by the nutritionist on the dietary orders and feeding protocols for all individuals. QMRP will administer monthly test to staff to ensure that all staff are knowledgeable and able to implement the dietary orders and also will check meal times and also will check meal times is unannounced to make sure staff is following all outlined protocols. QMRP will monitor meal time daily for two weeks, then monthly and at unannounced periods.</p> <p>Please See Attachment D.</p> | 06/30/08 | |
| W 249 | <p>483.410(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number</p> | W 249 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00G172. | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20018 |
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| (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 |
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| W 249 | <p>Continued From page 12</p> <p>and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide continuous active treatment for two of three clients included in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Upon entry to the facility, on June 4, 2008 at 7:25 AM, Client #2 approached the surveyor to inform her that an overnight staff person slapped him in the face. The investigation of complaint was initiated by interviewing the QMRP. According to the QMRP, the client complained about the staff person because he was upset about his toileting schedule. Interview with the direct care staff on June 5, 2008 at 3:20 PM revealed that he awakened the client at approximately 5:45 AM to implement his toileting schedule. However, the client had already soiled his pants. The direct care staff asked to client to go to the bathroom to get cleaned up. According to the staff, the client was awakened only once during the night because he would swear, use profanity and become physically aggressive. <p>Review of the Behavior Support Plan (BSP) dated February 8, 2008 revealed the following target behavior of toileting accidents. Further review revealed that the client should be awakened at midnight, 4:00 AM and around 6:00 AM. Staff were instructed to:</p> | W 249 | <p>The staff was retrained on 06/19/08 by the psychologist on the BSP for client #2 with emphasis on his toileting program. QMRP will ensure that staff are knowledgeable about the plan by periodic quizzes.</p> <p>Please See Attachment (E)</p> | 6/19/08 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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) COMPLETION DATE |
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| W 249 | <p>Continued From page 13</p> <ul style="list-style-type: none"> - Not to give the client any liquids after 8:00 PM; - During the night, take the client to the bathroom at 12:00 AM and 4:00 AM; - In the morning when the client gets up, have him change the sheets if they are wet and take to the laundry. If not say, "Good (the client) your sheets are dry;" and - Record all toileting data on the toileting data collection form. <p>Based on interview, the direct care were not implementing the BSP as written. According to the data for the past quarter revealed the scheduled is 8:00 AM - 9:00 AM and 4:00 PM - 10:00 PM. There was no available slots for overnight documentation.</p> <p>2. The facility failed to ensure Client #3's self medication program was implemented as written.</p> <p>Observation of the medication administration on June 4, 2008 at 7:40 AM revealed the nurse prepared the medication, and poured the water. The nurse spoon fed the medication to the client. Review of Client #3's self medication program revealed that he was required to: (1) pick up medication cup, (2) take medication, (3) drink water, and (4) put the cup in the trash. As a result of the nurse spoon feeding the client his medication, he was not afforded an opportunity to participate in his self medication program as written.</p> <p>3. The facility failed to implement Client #2's BSP.</p> |
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| W 249 | <p>On 06/09/08 the DON and QMRP retrained the medication nurses (LPN's) on the protocol in the administration of medication to all individuals with emphasis on privacy issues and self medication programs.</p> <p>Please See Attachment A.1</p> |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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 |
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W 249 Continued From page 14
On June 4, 2008 during evening observations, the direct care staff was overheard asking Client #2 at least two times, "did you keep your hands to yourself?, did you talk politely to others? and did you respect others property? The client replied, "Yes." Interview with the direct care staff on June 5, 2008 at approximately 11:00 AM indicated that the client had a BSP to address his maladaptive behaviors of physical and verbal aggression. Further interview revealed that the client get a monetary reward at the end of my shift (2:00 PM - 10:00 PM). Review of the BSP dated February 9, 2008 revealed the following target behaviors of physical and verbal aggression. A portion of the BSP includes a report card.

Staff should follow the steps outlined below:

- Every two hours the direct care staff will review the report card with the client. And ask the following questions: "Did you keep your hands to yourself?, did you talk politely to others? and did you respect others property?"
- If the client responds "yes" and the response is true, he will receive a score of "1". If he responds "no" and his response is true, the client will receive a score of "0". Staff should praise him for a score of "1."
- The next morning, if at least 80% of the clients score from the previous day were "1", the client will receive 50 cents so he can purchase a soda.
- On weekends, during the early shift, staff should review the client's report cards from the week with him. If at least 80% of the scores are 1's he should be given a special reinforcer.

W 249
The staff was retrained on 06/19/08 by the psychologist on the BSP for client #2 with emphasis on his toileting program. QMRP will ensure that staff are knowledgeable about the plan by periodic quizzes.
Please See Attachment 5

6-19

W 263 483.4.0(f)(3)(ii) PROGRAM MONITORING &

W 263

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/08/2008 |
|---|--|--|---|--------------------|--|
| NAME OF PROVIDER OR SUPPLIER D.C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 | | |
| (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 | |
| W 263 | <p>Continued From page 15</p> <p>CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor), or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of the three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #2's Behavior Support Plan. (See W124)</p> | W 263 | <p>The QMRP made several attempts to reach client #2 legal guardian by phone in order to get consent for client #2 psychotropic medication. However the guardian was traveling and could not be reached. QMRP will ensure that in future all consent are signed by guardian in a timely manner prior to administering any psychotropic medication.</p> <p>Please See Attached Consent for Client #2</p> | | |
| W 331 | <p>483.41 (c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's nursing staff failed to communicate to the primary care physician (PCP) concerns related to one of the three clients inability to swallow pills and failed to obtain X-ray results, timely for four of the six clients residing in the facility. (Clients #2, #3, #4 and #6)</p> <p>The findings include:</p> | W 331 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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) COMPLETION DATE |
|--------------------|--|---------------|---|------------------------|
| W 331 | Continued From page 16 1. The facility's nurse failed to obtain a chest X-Ray, timely. Review of Client #2's medical records on June 5, 2008 at 10:00 AM revealed a physician order dated May 12, 2008 for a chest X-Ray. Interview with the nurse indicated that the X-Ray had not been completed and one would be done soon. Further review of the medical record on June 6, 2008 at 9:30 AM revealed a medical consultation form that indicated that a chest X-ray had been completed at the local hospital dated June 5, 2008, nearly one month after the order. 2. Observations during the breakfast on June 4, 2008 at 7:16 AM, Client #3's was observed eating a chopped meal. At 7:40 AM, the client was observed during medication administration. The nurse prepared the medication, and poured the water. One pill (oyster shell with vitamin D) was noted to be a large green pill which the nurse spoon fed the client separately. The client drank four eight ounce cups of water to aid in swallowing the pill. Interview with the nurse on the same day revealed that the client had difficulty swallowing pills. Review of the client's medical record revealed that he had a diet order for all foods to be chopped. Interview with the nurse revealed that some of the client's medications could not be crushed to facilitate safe swallowing. When asked if the Primary Care Physician (PCP) was made aware that the client had problems swallowing the pills so that an alternative form could be considered; she indicated that the PCP had not been consulted. 3. On June 4, 2008 at 7:40 AM, the medication nurse was observed preparing the client | W 331 | The chest Xray for client #2 was completed on 06/05/08. The QMRP will ensure all medical orders are done on a timely manner. The primary care physician was contacted about Oyster Shell pill which client has problem in swallowing. After discussing with Pharmacist PMD ordered to crush above tablet. Nurses were told of above and follow the order. Nurse-in-charge will monitor to make sure above is followed properly, on a weekly basis. Please See Attachment A.3. | 6-5-08 06/05/08 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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 |
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| W 331 | <p>Continued From page 17</p> <p>medications. While preparing Client #3's medication, the nurse dropped one Aspirin pill on the floor and two Senna Gen tablets on the counter top. At 7:45 AM, the medication nurse was observed throwing the pills in the kitchen trash can. At 7:58 AM, the medication nurse was observed dropping Client #6's two Senna Gen pills on the counter top. Minutes later she was observed throwing the pills in the kitchen trash can. At 8:20 PM, the medication nurse dropped Client #4's Prilosec pill on the floor. And was later observed throwing the pill in the kitchen trash can.</p> <p>Interview with the medication nurse at approximately 8:30 AM revealed the policy stated, "the pills can be thrown in the trash." Review of the policy manual on June 4, 2008 at approximately 1:30 PM revealed a medication destroying policy. The policy indicated the following procedures:</p> <ul style="list-style-type: none"> - the medications can be destroyed in the facility; - have two witnesses present (licensed nurse, program directors, pharmacist or staff); - flush medication in the toilet; - have witnesses sign a destroying medication form; - notify nurse in charge; and - replacement order must be placed within 24 hours. | W 331 | <p>An in service training was given to nurses on 06/05/08 and 07/01/08 about dispensing medication and discarding medication. Also nurses were trained to follow all regulations from DCHC policy and procedure. Nurse-in-charge will monitor on weekly basis initially and then on monthly basis to ensure above.</p> <p>See Attachment A</p> | 06/05/08 and 07/01/08 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE! | | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 | | |
| (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 |
| 1000 | INITIAL COMMENTS A licensure survey was conducted from June 4, 2008 through June 6, 2008. A random sample of three residents was selected from a population of six males with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports. | 1000 | | |
| 1047 | 3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP are suited to the dietary needs of residents; as indicated in the individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that meals served away from the GHMRP suited the resident's dietary needs for one of the three residents in the sample. (Resident #2) The finding includes: The facility failed to ensure that Resident #2 received his prescribed diet at his day program. Observations at Resident #2's day program on June 4, 2008 at 12:35 PM, the resident was observed eating his lunch. The meal consisted of meatballs, noodles, okra with tomatoes, bread, applesauce, and 1% chocolate milk. At 1:05 PM, the resident completed his meal and walked to | 1047 | | |

Health Regulation Administration

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

Lydney S. Fisher

TITLE
President

(X5) DATE
7/3/08

LGR711

If continuation sheet 1 of 14

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HPD03-0197 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20018 |
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| (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 |
|--------------------|--|---------------|---|--------------------|
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| 1047 | Continued From page 1 his treatment room. During dinner observations at 6:40 PM, Resident #2 was observed eating sliced turkey, mashed potatoes, cabbage, bread and fruit cocktail. Review of Resident #2's current physician orders on June 5, 2008 at 10:00 AM revealed the resident was prescribed 1500 calorie diet with extra salad. Interview with the direct care staff who prepared the meal, indicated that she forgot to prepare the salad for Resident #2. | 1047 | The staff was retrained on 06/30/08 by the nutritionist on the dietary orders and feeding protocols for all individuals. QMRP will administer monthly test to staff to ensure that all staff are knowledgeable and able to implement the dietary orders and also will check meal times unannounced to make sure staff is following all outlined protocols. Please See Attachment | 06/30/08 |
| 1056 | 3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that each GHMRP staff were trained in the serving of residents dietary diet for two of the three residents in the sample. (Residents #2 and #5) The finding includes: 1. Observations at Resident #2's day program on June 4, 2008 at 12:35 PM, the resident was observed eating his lunch. The meal consisted of meatballs, noodles, okra with tomatoes, bread, applesauce, and 1% chocolate milk. At 1:05 PM, the resident completed his meal and walked to his treatment room. During dinner observations at 6:40 PM, Resident #2 was observed eating sliced turkey, mashed potatoes, cabbage, bread and fruit cocktail. | 1056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE! | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20010 | | |
| (X4) ID PREFIX TAG | BRIEF 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 |
| 1056 | <p>Continued From page 2</p> <p>Review of Resident #2's current physician orders on June 5, 2008 at 10:00 AM revealed the resident was prescribed 1500 calorie diet with extra salad. Interview with the direct care staff who prepared the meal, indicated that she forgot to prepare the salad for Resident #2.</p> <p>2. The GHMRP's staff failed to demonstrate competency in implementing clients feeding protocols for one of the six residents in the facility. (Resident #5)</p> <p>The finding include:</p> <p>During dinner observations on June 4, 2008 at 6:40 PM Resident #5 was observed sitting in a regular chair being fed a pureed textured diet from an elevated plate stand. The resident was observed coughing during dinner. The staff immediately stopped feeding him. At 6:49 PM, direct care staff was observed pouring two scoopsfuls of "Thick-It" into a cup of milk. Minutes later, the resident was observed drinking the milk with the added thickener independently. However, there was no noticeable change in the milk texture. At 6:55 PM, the direct care staff was interviewed to ascertain the texture of the liquid. The direct care staff could not recall the resident's prescribed liquid texture.</p> <p>At 7:05 PM the House Manager was interview about the dinner observation, the House Manager indicated that the client's liquid was required to be served in honey consistency. The direct care was immediately inserviced by the House Manger on the resident's liquid texture dietary order.</p> <p>On June 5, 2008 Resident #5's feeding protocol dated October 18, 2007 was reviewed and reflected the following guidelines/procedures:</p> | 1056 | <p>QMRP contacted case manager at [redacted] on 06/19/08 and discussed about client# 2's dietary order. On 07/01/08 met with direct care staff at [redacted] and gave an in service training. QMRP will visit day program on monthly basis to ensure that above is followed properly.</p> | 6-19-08 7-1-08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE 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) | (X5) COMPLETE DATE |
| 1056 | Continued From page 3 - Provide liquids in honey consistency; - Provide headrest for stability to avoid hyper-extension of head during swallowing; and - Sit upright for 30-45 minutes after the meal. There was no evidence that the facility implemented the above protocol. | 1058 | | |
| 1092 | 3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure it was maintained free from rodent and vermin. The findings include: On June 4, 2008 at 1:55 PM a mouse was observed to walk across the kitchen counter to the stove. The mouse walked from burner to burner and then disappeared into the stove. The nurse was present when the mouse was observed. Attempts were made to locate the mouse, however were unsuccessful. Small black specs was observed on the floor between the kitchen wall and the stove. Interview with the House Manager revealed that she had not observed any mice in the facility. Review of the facility's records revealed that the pest control contractor had last treated the facility for mice on February 5, 2008. The QMRP indicated that the pest control contractor would be contacted about the mouse. | 1092 | The pest control contractor serviced the facility on 06/06/08. The QMRP will ensure that the environment is kept neat and tidy and pest control services will be maintained on a monthly basis. | 06/06/08 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HPD03-0187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/08/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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 |
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| 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 GHMRP failed to ensure its staff received annual health screenings.</p> <p>The findings include:</p> <p>Interview and review of the personnel records on June 5, 2008 revealed the GHMRP failed to have evidence of physical examination for one direct care staff (Psychologist, and Nutritionist).</p> | 1206 | <p>On 06/06/08 the direct care staff was instructed to obtain her physical examination report. The staff has an appointment for physical exam on 07/14/08. Mean while the staff is on administration leave until the exam result are received.</p> <p>The health care certificate for psychologist and nutritionist is attached. Direct care staff is on leave pending physical exam</p> | 6-6-08 |
| 1227 | <p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have or file for review current training in First Aid and CPR for employees.</p> <p>The findings include:</p> <p>On June 5, 2008, review of personnel records training records revealed that two direct</p> | 1227 | | |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE: | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (X4) ID PREFIX TAG | B. PRIMARY 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 |
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| 1227 | Continued From page 5 care staffs are without current First Aid and CPR. (LM and JH). | 1227 | First aid and CPR training has been scheduled for all staff on 07/10/08. | |
| 1422 | <p>3521.3 HABILITATION AND TRAINING</p> <p>Each GMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for two of the three residents included in the sample. (Residents #2 and #3)</p> <p>The findings include:</p> <p>1. Upon entry to the facility, on June 4, 2008 at 7:25 AM, Client #2 approached the surveyor to inform her that an overnight staff person slapped him in the face. The investigation of complaint was initiated by interviewing the QMRP. According to the QMRP, the client complained about the staff person because he was upset about his toileting schedule. Interview with the direct care staff on June 5, 2008 at 3:20 PM revealed that he awakened the client at approximately 6:45 AM to implement his toileting schedule. However, the client had already soiled his pants. The direct care staff asked to client to go the bathroom to get cleaned up. According to the staff, the client was awakened only once during the night because he would swear, use profanity and become physically aggressive.</p> <p>Review of the Behavior Support Plan (BSP) dated February 9, 2008 revealed the following target behavior of toileting accidents. Further review</p> | 1422 | <p>The staff was retrained on 06/19/08 by the psychologist on the BSP for client #2 with emphasis on his toileting program. QMRP will ensure that staff are knowledgeable about the plan by periodic quizzes.</p> <p>Please See Attachment E.</p> | 06/19/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/06/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 | | |
| (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 |
| 1422 | <p>Continued From page 6</p> <p>revealed that the client should be awakened at midnight, 4:00 AM and around 6:00 AM. Staff were instructed to:</p> <ul style="list-style-type: none"> - Not to give the client any liquids after 6:00 PM; - During the night, take the client to the bathroom at 12:00 AM and 4:00 AM; - In the morning when the client gets up, have him change the sheets if they are wet and take to the laundry. If not say, "Good [the client] your sheets are dry;" and - Record all toileting data on the toileting data collection form. <p>Based on interview, the direct care were not implementing the BSP as written. According to the data for the past quarter revealed the scheduled is 6:00 AM - 9:00 AM and 4:00 PM - 10:00 PM. There was no available slots for overnight documentation.</p> <p>2. The facility failed to ensure Resident #3's self medication program was implemented as written.</p> <p>Observation of the medication administration on June 4, 2008 at 7:40 AM revealed the nurse prepared the medication, and poured the water. The nurse spoon fed the medication to the client. Review of Resident #3's self medication program revealed that he is to: (1) pick up medication cup, (2) take medication, (3) drink water, and (4) put the cup in the trash. Interview with the nurse on the same day revealed that the resident had difficulty swallowing pills. As a result of the nurse spoon feeding the resident his medication, he</p> | 1422 | <p>An in service training was given to nurses on 06/05/08 and 07/01/08 about dispensing medication and discarding medication. Also nurses were trained to follow all regulations from DCHC policy and procedure. Nurse-in-charge will monitor on weekly basis initially and then on monthly basis to ensure above.</p> <p>See Attachment A</p> | 06/05/08 and 07/01/08 |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20018 |
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| 1422 | <p>Continued From page 7</p> <p>was not afforded an opportunity to participate in his self medication program as written.</p> <p>3. The facility failed to implement Resident #2's BSP.</p> <p>On June 4, 2008 during evening observations, the direct care staff was overheard asking Resident #2 at least two times, "did you keep your hands to yourself?, did you talk politely to others?" and did you respect others property? The resident replied, "Yes." Interview with the direct care staff on June 5, 2008 at approximately 11:00 AM indicated that the resident had a BSP to address his maladaptive behaviors of physical and verbal aggression. Review of the BSP dated February 8, 2008 revealed the following target behaviors of physical and verbal aggression. A portion of the BSP includes a report card.</p> <p>Staff should follow the steps outlined below:</p> <ul style="list-style-type: none"> - Every two hours the direct care staff will review the report card with the resident. And ask the following questions: "Did you keep your hands to yourself?, did you talk politely to others? and did you respect others property?" - If the client responds "yes" and the response is true, he will receive a score of "1". If he responds "no" and his response is true, the resident will receive a score of "0". Staff should praise him for a score of "1." - The next morning, if at least 80% of the resident's score from the previous day were "1", the client will receive 50 cents so he can purchase a soda. - On weekends, during the early shift, staff should | 1422 | <p>3</p> <p>The staff was retrained on 06/19/18 by the psychologist on the BSP for client #2 with emphasis on his toileting program. QMRP will ensure that staff are knowledgeable about the plan by periodic quizzes.</p> <p>Please See Attachment. E</p> | |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| 1422 | <p>Continued From page 8</p> <p>review the resident's report cards from the week with him. If at least 80% of the score are 1's he should be given a special reinforcer.</p> <p>4. The facility failed to ensure that Resident #2 received his prescribed diet at his day program.</p> <p>Observations at Resident #2's day program on June 4, 2008 at 12:35 PM, the resident was observed eating his lunch. The meal consisted of meatballs, noodles, okra with tomatoes, bread, applesauce, and 1% chocolate milk. At 1:05 PM, the resident completed his meal and walked to his treatment room. During dinner observations at 8:40 P.M, Resident #2 was observed eating sliced turkey, mashed potatoes, cabbage, bread and fruit cocktail.</p> <p>Review of Resident #2's current physician orders on June 5, 2008 at 10:00 AM revealed the resident was prescribed 1500 calorie diet with extra salad. Interview with the direct care staff who prepared the meal, indicated that she forgot to prepare the salad for Resident #2.</p> <p>5. The facility failed to elevate Resident #3's leg while at the day program.</p> <p>On June 4, 2008 at 11:15 AM Resident #3 was observed at his day program. The resident was sitting in a chair with his feet on the floor watching television in a room with his peers. Review of the resident's record on the same day at approximately 3:30 PM revealed a Protocol for TED House effective January 1, 2008 that reflected the resident's feet should be elevated day, evening and night. The day program observation was brought to the attention of the House Manager and the Qualified Mental Retardation Professional (QMRP) on June 5,</p> | 1422 | <p>QMRP contacted case manager [redacted] on 06/19/08 and discussed about client #2's dietary order. On 07/01/08 met with direct care staff [redacted] and gave an in service training. QMRP will visit day program on monthly basis to ensure that above is followed properly.</p> <p>The QMRP retrained the day program staff on how to encourage client #3 to keep his legs elevated on 06/30/08. The QMRP will make monthly visit to ensure that the needs of clients #3 are met. QMRP had supplied the day program a stool on 01/08/08 for client #3 to use to elevate his legs. Please See Attachment C.</p> | 06/30/08 |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 |
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| 1422 | <p>Continued From page 9</p> <p>2008 at approximately 12:00 PM. They acknowledged the residents feet should have been elevated while the resident was sitting in the chair at the day program.</p> <p>6. The day program failed to notify the facility of an incident in which Resident #3 sustained an injury.</p> <p>Review of Resident #3's day program records on June 4, 2008 at approximately 11:30 AM revealed a nursing note dated July 17, 2007. The note indicated that the resident sustained an injury to his right knee after he fell while on an outing. The injury was described as an abrasion with skin peeling away, no bleeding or swelling. Interview with the day program's nurse on the same day at approximately 12:35 PM revealed that there had been no injuries to her knowledge. Interview with the QMRP on June 5, 2008 at approximately 2:00 PM revealed that he had no knowledge of the incident.</p> | 1422 | <p>6. On 06/30/08 the QMRP met with the program manager, the LPN and RN of [redacted] to address the need for proper communication from both sides. It was agreed that, effective immediately the day program will notify the QMRP by phone and letter of any incidents. The QMRP will ensure that the day program maintain good communication with the home and report injuries immediately.</p> <p>Please See Attachment (c)</p> | |
| 1500 | <p>3523.1 RESIDENT'S RIGHTS</p> <p>Each G HMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident rights for six of the six residents included in the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> | 1500 | | |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 | |

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| 1500 | Continue J From page 10 | 1500 | <p>The QMRP made several attempts to reach client #2 legal guardian by phone in order to get consent for client #2 psychotropic medication. However the guardian was traveling and could not be reached. QMRP will ensure that in future all consent are signed by guardian in a timely manner prior to administering any psychotropic medication.</p> <p>Please See Attached Consent for Client #2</p> | |
| | <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) on June 4, 2008 at 8:20 AM during the entrance conference indicated that Resident #2 receives psychotropic medication for his maladaptive behaviors. Review of the resident's current physician orders revealed that the resident also received Seroquel 25 mg and Buspar 5 mg in the evening. Further record review revealed that the Seroquel was ordered and implemented on March 17, 2008. According to the medication administration record on June 4, 2008 at 5:00 PM indicated that the medication was administered on the morning of March 18, 2008. Further record verification indicated that the medication was incorporated into the resident Behavior Support Plan (BSP) dated February 9, 2008 to address targeted behaviors that included verbal aggression and physical aggression.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on June 5, 2008 at approximately 9:30 AM revealed that Resident #2 had a court appointed guardian. Review of the resident's Psychological assessment dated June 26, 2007, at approximately 1:21 PM revealed that the resident did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Resident #2's guardian prior to the implementation of the Seroquel of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. [See Federal citation W124]</p> <p>2. The QMRP failed to ensure resident privacy.</p> <p>The morning medication pass was observed on</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD83-0187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/08/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 809 14TH STREET, SE WASHINGTON, DC 20019 |
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| 1500 | <p>Continued From page 11</p> <p>June 4, 2008 from 7:40 AM to 8:20 AM: The residents were seated at the dining room table eating their breakfast. The nurse administered each of their medications while they sat at the table with staff.</p> <p>During an interview with the nurse on the same day, she acknowledged the lack of privacy during the medication administration. [See Federal citation V/130]</p> <p>3. The GHRM's staff failed to demonstrate competency in implementing resident's feeding protocols for one of the six clients in the facility. (Resident #5)</p> <p>The finding include:</p> <p>During dinner observations on June 4, 2008 at 6:40 PM, Resident #5 was observed sitting in a regular chair being fed a pureed textured diet from an elevated plate stand. The resident was observed coughing during dinner. The staff immediately stopped feeding him. At 6:49 PM, direct care staff was observed pouring two scoopsful of "Thick-It" into a cup of milk. Minutes later, the resident was observed drinking the milk with the added thickener independently. However, there was no noticeable change in the milk texture. At 6:55 PM, the direct care staff was interviewed to ascertain the texture of the liquid. The direct care staff could not recall the client's prescribed liquid texture.</p> <p>At 7:05 PM the House Manager was interviewed about the dinner observation, the House Manager indicated that the client's liquid was required to be served in honey consistency. The direct care was immediately inserviced by the House Manger on the client's liquid texture dietary order.</p> | 1500 | <p>On 06/09/08 the DON and QMRP retrained the medication nurses (LPN's) on the protocol in the administration of medication to all individuals with emphasis on privacy issues and self medication programs.</p> <p>Please See Attachment A.</p> | 06/09/08 |

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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE, | STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019 |
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| 1500 | <p>Continued From page 12</p> <p>On June 5, 2008 Resident #5's feeding protocol dated October 18, 2007 was reviewed and reflected the following guidelines/procedures:</p> <ul style="list-style-type: none"> - Provide liquids in honey consistency; - Provide headrest for stability to avoid hyper-extension of head during swallowing; and - Sit upright for 30-45 minutes after the meal. <p>There was no evidence that the facility implemented the above protocol. [See Federal citation V/194]</p> <p>4. The GHMRP failed to ensure the nursing staff administered medications in compliance with the residents diet order.</p> <p>Observations during the breakfast on June 4, 2008 at 7:15 AM, Client #3's was observed eating a chopped meal. At 7:40 AM, the client was observed during medication administration. The nurse prepared the medication, and poured the water. One pill (oyster shell with vitamin D) was noted to be a large green pill which the nurse spoon fed the client separately. The client drank 32 ounces (four eight ounce cups of water) to aid in swallowing the pill. Interview with the nurse on the same day revealed that the client had difficulty swallowing pills. Review of the clients medical record revealed that he had a diet order for all foods to be chopped. Interview with the nurse revealed that some of the clients medications could not be crushed to facilitate safe swallowing. When asked if the Primary Care Physician (PCP) was made aware that the client had problems swallowing the pills so that an alternative form could be considered, she</p> | 1500 | <p>The staff was retrained on 06/30/08 by the nutritionist on the dietary orders and feeding protocols for all individuals. QMRP will administer monthly test to staff to ensure that all staff are knowledgeable and able to implement the dietary orders and also will check meal times unannounced to make sure staff is following all outlined protocols.</p> <p>Please See Attachment D.</p> | 06/30/08 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0187 | DC2 MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (05) DATE SURVEY COMPLETED 06/05/2008 |
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| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 803 14TH STREET, SE WASHINGTON, DC 20019 |
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| (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) | (06) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| 1500 | Continued From page 13 indicated that the PCP had not been consulted. | 1500 | | |