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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		06/23/2010

NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 248 WALNUT STREET, NW, WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS	W 000		
	An recertification survey was conducted from June 22, 2010, through June 23, 2010, utilizing the fundamental survey process. 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 were based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.		Received 8/6/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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, staff interview and record review, the facility failed to ensure outside services met the clients needs, of one client included in the sample. (Client #1) The findings include: I. On June 22, 2010, beginning at 12:05 p.m., Client #1 was observed at his day program. At 12:28 p.m., the day program staff assisted the client to sit down. A step stool was positioned slightly under the client's chair. Interview with the day program Registered Nurse (RN) and the day program staff on June 22, 2010, at 1:10 p.m., revealed Client #1 has an order to elevate his feet during the day. After the interview Client #1 was observed with his feet elevated on	W 120	I. QMRP visited the day program and an In-service with the staff of the Day Program regarding feet elevation protocol, was done on July 15, 2010. QMRP and House Manager will make monthly visit to ensure proper implementation of the program. An updated copy of the protocol was also provided to the day program at the time (See Attachment A1)	07-15-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mamta Tiwari
TITLE: Deputy Director / D.C.H.C
(X6) DATE: 8-5-10

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.

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W 120	Continued From page 1 the step stool. On June 23, 2010, at 10:23 a.m., review of Client #1's physician order dated, June 1, 2010, revealed an order for the client to "keep legs elevated when seated during the day." The facility failed to ensure that day program staff encouraged Client #1 to elevate his feet as prescribed. 2. Interview with the day program RN on June 22, 2010, at 12:40 p.m., revealed the day program did not have a current Individual support plan (ISP). Further interview revealed that the RN made several attempts to retrieve the client's ISP. Record review on the same day at 12:47 p.m., revealed the RN sent three notes to the Qualified Mental Retardation Professional (QMRP) requesting the client's current ISP. Further review revealed an ISP dated July 17, 2008. In an interview with the QMRP on June 23, 2010, at approximately 2:30 p.m., she acknowledged that the day program did not have a current ISP.	W 120	2. A current ISP was provided to the day program on July 15, 2010. QMRP will ensure that all the required documents at the day program are up to date and available during monthly visits. An In-Service training was completed with QMRP by Program Manager on 06-28-10 Program Manager will monitor for compliance on regular basis through calls and visits. (See Attachment "A2" and H)	07-15-2010 06-28-2010
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients residing in the facility. (Client #6) The finding includes:	W 130		

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W 130	Continued From page 2	W 130	An In-Service training was done on 08-03-10 for all direct care staff on privacy issues with the individuals. QMRP/ House Manager will continue to monitor on daily basis and also to continue with quarterly training and retraining of all the staff. (See Attachment "B")	08-03-10
	On June 22, 2010, at 7:38 a.m., Client #6 was observed sitting on the toilet with the door wide open while the direct care staff was assisting other clients with their breakfast. At 7:45 a.m., the qualified mental retardation professional (QMRP) walked by and closes the door. When interviewed at approximately 10:30 a.m., the QMRP acknowledged that Client #6 was not provided privacy while using the bathroom.			
	There was no evidence that staff ensured privacy during Client #6's personal care.			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		
	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 review of the client's records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator and to the State agency, for one of the three clients included in the sample. (Clients #1)			
	The finding includes:			
	Review of Client #1's day program nursing note dated January 11, 2010, on June 22, 2010, at approximately 1:15 p.m., revealed that Client #1 was observed as soon as he entered his day program with a bruise on his forehead.			

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W 153	Continued From page 3 Interview with the day program registered nurse (RN) on the same day at 1:18 p.m., revealed that the qualified mental retardation professional (QMRP) was informed. Interview with the QMRP on June 23, 2010, at approximately 3:00 p.m., confirmed the day program made her aware of the client's bruise. Further interview revealed there was no incident report completed for the bruise on Client #1's forehead. There was no evidence the facility reported the injury of unknown origin to the administrator or to the Department of Health.	W 153	An In-service training was done with QMRP and House Manager by the Program Manager / Incident Management Coordinator on 06-28-10 regarding policy and procedure of reporting and following incidents. QMRP will make sure to report all incidents to Incident Management Coordinator at the time of the incident to ensure that all incidents as per protocol has been reported and investigated. Incident management coordinator will monitor the facility on quarterly basis for compliance. (See Attachment "C")	6-28-10
W 194	483.430(e)(1) 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 eating precautions protocol, for one of the three clients included in the sample. (Client #2) The finding includes: During meal observation on June 22, 2010, at 7:40 p.m., Client #2 was observed eating dinner, using his fingers. The client held a fork in his right hand and used his fingers to pick up the rice, broccoli and meat. While the client was eating the rice portion, the staff asked the client to use his utensils, to no avail. As the client ate the	W 194	An In-service training was done on 08/03/10 with all staff regarding eating protocols. All protocols were reviewed and discussed. QMRP/House Manager will ensure proper implementation of the protocols by monitoring /observing and filling a meal time observation sheet and reviewing the data with Program Manager on monthly basis for	08-03-10

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W 194	Continued From page 4 broccoli and meat with his fingers, there was no staff intervention. After the client completed his food, he scraped the plate with his fingers and began to lick his fingers clean. By the time, the program director assistance intervened, the plate was cleaned. After staff intervention, the client was observed taking his plate to the kitchen sink and sitting on the sofa. The client was observed bringing food up and chewing on the food (ruminating his food). The direct care staff attempted to get the client to drink a cup of water. Interview with the direct care staff on June 22, 2010, at 7:55 p.m., revealed that the client ruminates his food. Review of the Client #2's eating precaution protocol dated February 9, 2009, on June 23, 2010, at 11:00 a.m., revealed the following guidelines: - provide verbal prompting to put your spoon down to help reduce his rate of eating and decrease the amount of food that the client puts in his mouth; - alternating solids with sips of a beverage is a good way to clear his mouth; however he usually prefers to drink after his meal; - encourage him to use a napkin to wipe his mouth after mouthful; and - add some juice to his water so the client will consume after his meal. Interview with the qualified mental retardation professional and assistant program director on June 23, 2010, at approximately 11:00 a.m.,	W 194	three consecutive months. See Attachment "D1" and "D2".	

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	09G183		06/23/2010

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W 194	Continued From page 5	W 194		
	confirmed that the facility failed to implement Client #2's eating protocol.			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		
	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 and frequency to support the achievement of the objectives identified in the individual program plan.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure continuous active treatment, for one of the three clients in the sample. (Client #2)			
	The finding includes:			
	The facility staff failed to implement Client #2's communication Individual Program Plan (IPP).		An In-Service training was done with all direct care staff on 08-03-10 regarding program implementation. QMRP/House Manager will monitor the above and also will retrain staff on quarterly or as needed basis to ensure proper implementation of program as outlined. Program Manager will check program implementation during routine visits. (See Attachment E)	08-03-10
	Observations on June 22, 2010, at 5:00 p.m., staff was observed holding two items (box of popsicle sticks and a lighted wheel) in front of Client #2 and asking, "which one would you like". Client #2 was observed taking the box of popsicle sticks and pulling them under the sofa. Several minutes later, the direct care staff was observed retrieving the box from under the sofa and asking the client again, "which one would you like". The client was observed pushing the items away and walking around the facility.			
	Interview with the direct staff indicated that the			

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W 249	Continued From page 6 client likes to play with the popsicle sticks and he will usually selects them. Review of Client #2's IPP dated August 21, 2009, on June 23, 2010, at approximately 1:00 p.m., revealed a program objective which stated, "[the client] will use a picture exchange system to express a need, want, or desire with 25% independence within one year. Further review of the task analysis sheet indicated that the should implement the program as follows: - staff will give him a picture of the client using the popsicle sticks or a buzzer. If the client does not accept the picture, staff should place the picture in his hands - staff will prompt him to look at picture; - staff will say the phrase, "[the client] has the sticks or buzzer; -[the client] will hand the picture back to the staff. If [the client] does not give the picture back, staff should provide hand over hand assistance; - staff will give him the object in the picture; and - staff will document the client's performance. Interview with the qualified mental retardation professional (QMRP)on June 23, 2010, at approximately 1:10 p.m., confirmed that the staff did not use any pictures as the program instructs. There was no evidence that the staff implemented Client #2's communication goal.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria	W 252		

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W 252	Continued From page 7 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the three clients in the sample. (Client #3) The finding includes: On June 22, 2010, at 4:40 p.m., Client #3 was observed drinking from a cup sitting on the living room table. The direct care staff asked the client to STOP and removed the cup from the client's hand. Interview with the direct care staff on June 22, 2010, at 5:10 p.m., indicated that Client #3 has a behavior support plan (BSP) to address behaviors of food stealing. Record verification on June 23, 2010, at 9:10 a.m., revealed Client #3's BSP dated April 12, 2010, that identified a maladaptive behavior of food stealing. According to the data collection instructions, staff are to document all incidents in the Behavior Management section of the Individual program plan (IPP) book. Further review of the data chart on June 23, 2010, at 9:40 a.m. revealed that the client had no behaviors documented of food stealing on June 22, 2010. Interview with the qualified mental retardation professional confirmed that the staff failed to document Client #3's incident of food stealing.	W 252	An In-service training was done with all direct care staff on 08-03-10 by the Psychologist regarding proper intervention and documentation of Behavior Support Plan. QMRP and House Manager will monitor the above on daily basis. Also QMRP/ House Manager will retrain staff on quarterly to ensure proper implementation of program. Program Manager will check program implementation during routine visits. (See Attachment F)	08-03-10

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W 252	Continued From page 8	W 252		
	There was no evidence that data had been collected in accordance with the client's BSP, which was necessary for a functional assessment of the client's progress.			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262		
	The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.			
	This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for one of three clients in the sample. (Client #2)			
	The finding includes:			
	Minutes taken at meetings of the facility's HRC for the period June 2009 through June 8, 2010, were reviewed on June 23, 2010, beginning at 12:25 p.m. Review of Client #2's medical chart on June 22, 2010, beginning at 9:45 a.m., revealed the following orders for sedation:			
	- Ativan 3 mg prior to an ENT appointment scheduled for June 7, 2010;			
	- Ativan 3 mg prior to a dental appointment scheduled on June 2, 2010; and			
	- Ativan 3 mg prior to an audiology appointment.			
	Interview with the qualified mental retardation			

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W 262	Continued From page 9 professional (QMRP), and further record review on June 23, 2010, at 3:00 p.m., revealed that Client #2 received the sedations to address his non-compliance behaviors prior to the medical appointments. Further interview with the program director at 4:00 p.m., indicated that the HRC discussed the client's sedations, however there was no evidence that the HRC approved the use of sedations for Client #2.	W 262	HRC minutes dated 6-8-10 were amended to include the discussion and approval of client # 2's sedations as it was reviewed at the meeting but not included by mistake in the HRC summary by QMRP. In-Service and review of the HRC minutes with QMRP by Program Manager was conducted on 07/08/10 to include all information on sedation and medical appts for review by HRC Program Manager will review minutes prior to filing HRC minutes to ensure that all discussed information are included in the minutes. (See Attachment G1 and G2)	7-8-10
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure consistent implementation of quarterly reviews, for one of three clients in the sample. (Client #1) The finding includes: Review of Client #1's medical record on June 23, 2010, at 10:50 a.m., revealed an annual nursing assessment dated June 25, 2009. Further review of the client's record revealed there was no nursing quarterly assessment in the record prior to December 8, 2009. Interview with the Qualified Mental Retardation Professional (QMRP) on June 23, 2010, at approximately 3:30 p.m., revealed that nursing quarterlies are required to be completed every quarter (3 months).	W 336	Nursing quarterly in question was retrieved from the main office at the time of the survey and was placed in the book. This was an oversight by QMRP. An In-service training was done by the Program Manager on 07-21-10 on "Record keeping and filing of documents" QMRP will check the books on quarterly basis to make sure all information are filed and are current. Program Manager will do audit of books on quarterly basis (See Attachment "H")	06-23-10 & 07-21-10
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair,	W 436		

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W 436	Continued From page 10	W 436		
	and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.			
	This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility's nurse failed to use clients adaptive drinking cup as recommended, for two of the three clients included in the sample. (Clients #1 and #3)			
	The findings include:			
	1. Meal observations on June 22, 2010, at 4:15 p.m., Client #1 was observed having a snack. During the meal he was observed drinking from a sippy cup with handles. At 5:05 p.m., during dinner observations, Client #1 was observed using a sippy cup with handles. During the medication observation at 6:35 p.m., Client #1 was observed consuming his medication with water provided in a styrofoam cup. As the client consumed the water, the liquid was observed running out of his mouth and onto his shirt.	1 & 2	An In-service training was conducted with nurse on use of adaptive equipment on 07-06-10. Nursing staff is using adaptive equipment for individuals (e.g - sippy cups, special spoons or other needful devices) QMRP and House Manager will monitor the above or daily basis. Also registered nurse and Program Manager will check unannounced for implementation of above. (See Attachment I)	07-06-10
	Interview with LPN, after the medication administration, indicated that all the clients used the same type of cup and no one used adaptive drinking cups during the medication administration.			
	According to Client #1's Individual Support Plan (ISP) dated July 17, 2009, on June 23, 2010, at 1:30 p.m., it was recommended and confirmed that the client should consume all his liquids from			

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W 436	Continued From page 11 a sippy cup. 2. During meal observations on June 22, 2010, at 8:30 a.m., and 4:15 p.m., Client #3 was observed drinking his beverage using a sippy cup with handles. During the medication observation at 7:00 p.m., Client #3 was observed consuming his medication with water provided in a styrofoam cup. As the client consumed the water, the liquid was observed running out of his mouth, down his chin and onto his shirt. Further observations revealed the client coughing after he consumed the liquids. At 7:40 p.m. during dinner observations, Client #3 was observed drinkin his beverage using a sippy cup with handles. Interview with LPN, after the medication administration, indicated that all the clients use the same type of cup and no one used adaptive feeding cups during the medication administration. Review of Client #3's medical record indicated a diagnosis of oral dysphagia. Further review of Client #3's feeding protocol dated March 10, 2010, on June 23, 2010, at approximately 9:50 a.m., recommended the following feeding adaptive equipment: sippy cup, sectional plate, plate riser, etc.... According to the Individual Support Plan (ISP) dated March 16, 2010, on June 23, 2010, at 11:30 a.m., confirmed the following adaptive equipment: sippy cup with handles, weighted teaspoon, divided plate, plate riser and slip resistant mat under plate. Interview with the QMRP and program director on June 23, 2010, at approximately 4:00 p.m., confirmed that clients #1 and #3. the should use	W 436		

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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		06/23/2010

NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 248 WALNUT STREET, NW, WASHINGTON, DC 20011

(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 436	Continued From page 12 the adaptive sippy cup during medication administration, as well. At the time of the survey, the facility's nurse failed to ensure clients untilized recommended adaptive equipment during medication administration.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one of the seven shifts of duty reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 22, 2010, at 10:20 a.m. revealed the following staffing pattern: Sunday - Saturday 6:30 a.m. - 2:30 p.m.; 2:30 p.m.-10:30 p.m.; 10:30 p.m. - 6:30 a.m.; Monday-Friday 6:30 a.m. -10:30 a.m.; 10:30 a.m. - 2:30 p.m.; 2:30 p.m. to 10:30 p.m. and 10:30 p.m. to 6:30 a.m. Review of the fire drill log revealed that the weekend shift for 6:30 a.m.-2:30 p.m., from June 2009 to June 2010, failed to hold evacuation drills	W 440	An In-service was conducted with all staff on 7-29-10, for quarterly fire drills per shift as per D.C.H.C policy, House Manager and QMRP will review fire drill reports monthly to ensure drills are conducted on each shift as required. Program Manager will review fire drill log on quarterly basis (See Attachment "D1")	07-29-10

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W 440	Continued From page 13 per shift per quarter. There was no evidence that the facility held fire drills at least quarterly for each shift of personnel.	W 440		
W 455	483.470(i)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure an active program for the prevention and control of infection, for one of the two clients included in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3 washed his hands prior to eating his breakfast. On June 22, 2010, at 8:25 a.m., Client #3 was observed entering his home and sitting at the dining room table. Minutes later, the direct care staff was observed bringing a plate of food and sitting it in front of the client. Seconds later, the client began to eat from the plate. Interview with the Staff #1 at 8:35 a.m., indicated that Client #3 had been to the lab to have his blood sugar monitored. Interview with the Staff #2 on June 22, 2010, at 8:50 a.m., confirmed that she did not assist Client #3 with washing his hands, prior to his breakfast. There was no evidence that the staff provided proper infection control procedures prior the client's meal time.	W 455	An In-service training was conducted with all staff on 08-03-10 for infection control and universal precautions for hand-washing. QMRP and House Manager to observe for implementation of above. QMRP will conduct quarterly In-Service with all staff on proper infection control and will continue to monitor at different times. (See Attachment D1 and D3)	08-03-10

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Health Regulation Administration

PRINTED: 07/27/2010
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0188	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/23/2010
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20011		

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I 000	INITIAL COMMENTS An re-licensuresurvey was conducted from June 22, 2010, through June 23, 2010, utilizing the full survey process. 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 were based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	I 000		
I 109	3504.16 HOUSEKEEPING Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP). This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that clothing items were labeled inconspicuously, for one of the six residents residing in the facility. (Resident #5) The finding includes: On June 22, 2010 at 8:30 a.m., Resident #5 was observed wearing a pair of long white tube socks. Resident #5's initials were written across the front of the tube socks in large black letters. Interview with the direct care staff confirmed that the resident's initial's were written on the front of his socks. During the exit conference on June 23, 2010, at 4:45 p.m., the qualified mental retardation professional and assistant program	I 109	An In-Service training was conducted on 6-28-10 by Program Manager to QMRP and House Manager on how to label clothes properly with permanent marker in such away that individuals dignity and privacy are protected. QMRP will check individuals clothes on weekly basis to ensure that they are weather appropriate and in good repair. Also will circulate unwanted clothing and maintain seasonal clothing in their drawers for use. (See Attachment "J")	06-28-10

Health Regulation Administration

Mamta Tiwari

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

TITLE Deputy Director | DCHC

(X6) DATE 8/5/10

STATE FORM

WLNQ11

If continuation sheet 1 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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I 109	Continued From page 1 director acknowledged they also had seen the initials on his socks.	I 109		
I 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 at least quarterly, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 22, 2010, at 10:20 a.m. revealed the following staffing pattern: Sunday - Saturday 6:30 a.m. - 2:30 p.m.; 2:30 p.m.-10:30 p.m.; 10:30 p.m. - 6:30 a.m.: Monday-Friday 6:30 a.m. -10:30 a.m.; 10:30 a.m. - 2:30 p.m.; 2:30 p.m. to 10:30 p.m. and 10:30 p.m. to 6:30 a.m. Review of the fire drill log revealed that the weekend shift for 6:30 a.m.-2:30 p.m., from June 2009 to June 2010, failed to hold evacuation drills per shift per quarter. There was no evidence that the facility held fire drills at least quarterly for each shift of personnel.	I 135		

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	HFD03-0188		06/23/2010
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I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing residents' mealtime protocol, for two of the three residents in the sample. (Residents #1, #2 and #3) The findings include: 1. During meal observation on June 22, 2010, at 7:40 p.m., Resident #2 was observed eating dinner, using his fingers. The resident held a fork in his right hand and used his fingers to pick up the rice, broccoli and meat. While the resident was eating the rice portion, the staff asked the resident to use his utensils, to no avail. As the resident ate the broccoli and meat with his fingers, there was no staff intervention. After the resident completed his food, he scraped the plate with his fingers and began to lick his fingers clean. By the time, the program director intervened, the plate was cleaned. After staff intervention, Resident #2 was observed taking his plate to the kitchen sink and sitting on the sofa. The resident was observed bringing food up and chewing on the food (ruminating his food). The direct care staff attempted to get the resident to drink a cup of water.	I 229	An In-service was conducted with all staff on 7-29-10, for quarterly fire drills per shift as per D.C.H.C policy. House Manager and QMRP will review fire drill reports monthly to ensure drills are conducted on each shift is required. Program Manager will review fire drill on quarterly basis (See Attachment D1) An In-service training was done on 08/03/10 with all staff regarding eating protocols. All protocols were reviewed and discussed. QMRP/House Manager will ensure proper implementation of the protocols by monitoring /observing and filling a meal time observation sheet and reviewing the data with Program Manager on monthly basis for three consecutive months. (See Attachment D1 and D2)	7-29-10 08-03-10

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I 229	Continued From page 3	I 229		
	Interview with the direct care staff on June 22, 2010, at 7:56 p.m., revealed that the resident ruminates his food. Review of the Resident #2's eating precaution dated February 9, 2009, on June 23, 2010, at 11:30 a.m., revealed the following guidelines: - provide verbal prompting to put your spoon down to help reduce his rate of eating and decrease the amount of food that the resident puts in his mouth; - alternating solids with sips of a beverage is a good way to clear his mouth; however he usually prefers to drink after his meal; - encourage him to use a napkin to wipe his mouth after mouthful; and - add some juice to his water so the resident will consume after his meal. Interview with the qualified mental retardation professional and assistant program director on June 23, 2010, at approximately 11:00 a.m., confirmed that the facility failed to implement Resident #2's eating protocol.			
	2. Meal observations on June 22, 2010, at 4:15 p.m., Resident #1 was observed having a snack. During the meal he was observed drinking from a sippy cup with handles. At 5:05 p.m., during dinner observations, Resident #1 was observed using a sippy cup with handles. During the medication observation at 6:35 p.m., Resident #1 was observed consuming his medication with water provided in a styrofoam cup. As the Resident consumed the water, the liquid was	2&3	An In-service training was conducted with nurse on use of adaptive equipment on 07-06-10. Nursing staff is using adaptive equipment for individuals (e.g - sippy cups, special spoons or other needful devices) QMRP and House Manager will monitor the above or daily basis. Also registered nurse and Program Manager will check unannounced for implementation of above. (See Attachment I)	7-6-10

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I 229	Continued From page 4 observed running out of his mouth and onto his shirt. Interview with LPN, after the medication administration, indicated that all the Residents used the same type of cup and no one used adaptive drinking cups during the medication administration. According to Resident #1's Individual Support Plan (ISP) dated July 17, 2009, on June 23, 2010, at 1:30 p.m., it was recommended and confirmed that the resident should consume all his liquids from a sippy cup. 3. During meal observations on June 22, 2010, at 8:30 a.m., and 4:15 p.m., Resident #3 was observed drinking his beverage using a sippy cup with handles During the medication observation at 7:00 p.m., Resident #3 was observed consuming his medication with water provided in a styrofoam cup. As the resident consumed the water, the liquid was observed running out of his mouth, down his chin and onto his shirt. Further observations revealed the resident coughing after he consumed the liquids. At 7:40 p.m during dinner observations, Resident #3 was observed drinkin his beverage using a sippy cup with handles. Interview with LPN, after the medication administration, indicated that all the Residents use the same type of cup and no one used adaptive feeding cups during the medication administration. Review of Resident #3's medical record indicated a diagnosis of oral dysphagia. Further review of Resident #3's feeding protocol dated March 10,	I 229		

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I 229	Continued From page 5	I 229		
	2010, on June 23, 2010, at approximately 9:50 a.m., recommended the following feeding adaptive equipment: sippy cup, sectional plate, plate riser, etc.... According to the Individual Support Plan (ISP) dated March 16, 2010, on June 23, 2010, at 11:30 a.m., confirmed the following adaptive equipment: sippy cup with handles, weighted teaspoon, divided plate, plate riser and slip resistant mat under plate. Interview with the QMRP and program director on June 23, 2010, at approximately 4:00 p.m., confirmed that Residents #1 and #3, the should use the adaptive sippy cup during medication administration, as well. At the time of the survey, the facility's nurse failed to ensure residents untilized recommended adaptive equipment during medication administration.			
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide habilitation and training, for one of the three	I 437		

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I 437	Continued From page 6 residents included in the sample. (Resident #2) The finding includes: The facility staff failed to implement Resident #2's communication Individual Program Plan (IPP). Observations on June 22, 2010, at 5:00 p.m., staff was observed holding two items (box of popsicle sticks and a lighted wheel) in front of Resident #2 and asking, "which one would you like". Resident #2 was observed taking the box of popsicle sticks and putting them under the sofa. Several minutes later, the direct care staff was observed retrieving the box from under the sofa and asking the resident again, "which one would you like". The resident was observed pushing the items away and walking around the facility. Interview with the direct staff indicated that the resident like to play with the popsicle sticks and he will usually select them. Review of Resident #2's IPP dated August 21, 2009, on June 23, 2010, at approximately 1:00 p.m., revealed a program objective which stated, "[the client] will use a picture exchange system to express a need, want, or desire with 25% independence within one year. Further review of the task analysis sheet indicated that the should implement the program as follows: - staff will give him a picture of the resident using the popsicle sticks or a buzzer. If the resident does not accept the picture, staff should place the picture in his hands; - staff will prompts him to look at picture;	I 437	An In-Service training was done with all direct care staff on 08-03-10 regarding program implementation. QMRP/House Manager will monitor the above and also will retrain staff on quarterly or as needed basis to ensure proper implementation of program as outlined. Program Manager will check program implementation during routine visits. (See Attachment E)	8-3-10

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I 437	Continued From page 7	I 437		
	- staff will say the phrase, "[the resident] has the sticks or buzzer;			
	-[the resident] will hand the picture back to the staff. If [the client] does not give the picture back, staff should provided hand over hand assistance;			
	- staff will give him the object in the picture; and			
	- staff will document the resident's performance.			
	Interview with the qualified mental retardation professional on June 23, 2010, at approximately 1:10 p.m., confirmed that the staff did not use any pictures as the program instructs. There was no evidence that the staff implemented Resident #2's communication goal.			
I 500	3523.1 RESIDENT'S RIGHTS	I 500		
	Each GHMRP 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.			
	This Statute is not met as evidenced by: Based on observations, interviews and record review, the the Group Home for the Mentally Retarded Persons (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the three residents included in the sample. (Resident #2)			
	The finding includes:			

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I 500	Continued From page 8 Minutes taken at meetings of the facility's HRC for the period June 2009, through June 8, 2010, were reviewed on June 23, 2010, beginning at 12:25 p.m. Review of Resident #2's medical chart on June 22, 2010, beginning at 9:45 a.m., revealed the following orders for sedation: - Ativan 3 mg prior to an ENT appointment scheduled for June 7, 2010; - Ativan 3 mg prior to a dental appointment scheduled on June 2, 2010; and - Ativan 3 mg prior to an audiology appointment. Interview with the qualified mental retardation professional (QMRP), and further record review on June 23, 2010, at 3:00 p.m., revealed that Resident #2 received the sedations to address his non-compliance behaviors prior to the medical appointments. Further interview with the program director at 4:00 p.m., indicated that the HRC discussed the resident's sedations, however there was no evidence that the HRC approved the use of sedations for Resident #2.	I 500	HRC minutes dated 6-8-10 were amended to include the discussion and approval of client # 2's sedations as it was reviewed at the meeting but not included by mistake in the HRC summary by QMRP. In-Service and review of the HRC minutes with QMRP by Program Manager was conducted on 07/08/10 to include all information on sedation and medical appts for review by HRC Program Manager will review minutes prior to filing HRC minutes to ensure that all discussed information are included in the minutes. (See Attachment G1 and G2)	07-08-10