

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from September 1, 2009 through September 3, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of one female client and five male clients with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.</p>	W 000	<p><i>Received 10/1/09</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 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the qualified mental retardation professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs, for three of three clients included in the sample at the time of the survey. (Clients #1, #2, and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross Refer to W249. The QMRP failed to implement Client #1's snack program. 2. Cross Refer to W252. The QMRP failed to ensure that data was collected in the form and required frequency, for two of the three clients in 	W 159	<p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p> <p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p>	9-4-09 9-4-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maura Cinkari</i>	TITLE <i>Deputy Director</i>	(X6) DATE <i>9-30-09</i>
---	-------------------------------------	---------------------------------

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: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 159	Continued From page 1 the sample. (Clients #1 and #2)	W 159		
W 249	<p>483.440(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 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 one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to implement Client #1's Individual Program Plan (IPP) as evidenced by the following:</p> <p>During the evening observation on September 1, 2009, at 4:01 p.m., a tray of snacks was observed in the kitchen refrigerator. The snacks consisted of 100 calorie cakes, pudding cups, fiber bars and peanut butter crackers. At 4:45 p.m., the House Manger was observed setting the tray of snack on the dining room table. At 5:11 p.m., Clients #1,</p>	W 249	<p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p>	9-4-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 249	<p>Continued from page 2</p> <p>#4, and #5 selected their choice of snack from the tray. At 5:15 p.m., the House Manager was observed assisting Client #1 with passing out a snack to Client #3. At 5:17 p.m., Client #2 was given a choice of snack from the direct care staff.</p> <p>Review of the Client #1's Individual Program Plan (IPP) on September 2, 2009, at approximately 9:35 a.m., revealed the client had a program to pass out snacks to her peers that reflected the following steps:</p> <ul style="list-style-type: none"> - will place all snacks on a tray; - will individually pass out the snack to each one of her peers; and - will take tray to kitchen. <p>Interview with the House Manager on September 2, 2009, at approximately 11:00 a.m., indicated that the client required a lot of assistance to complete the task further acknowledging that Client #1 was not given the opportunity to participate in the aforementioned program.</p> <p>There was no evidence that the QMRP ensured that Client #1 was given the opportunity to participate in the aforementioned program.</p>	W 249		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record verification, the facility failed to ensure that data</p>	W 252	<p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p>	9-4-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003	
(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 252	<p>Continued from page 3</p> <p>was collected in the form and required frequency, for two of the three clients in the sample. (Clients #1 and #2)</p> <p>The finding(s) include:</p> <p>1. On September 1, 2009, at 5:35 p.m., Client #1 was observed going for a walk in the community. Interview with the direct care staff on September 1, 2009, at 11:45 p.m., confirmed that Client #1 went on a community walk.</p> <p>Review of the Client #1's Individual Program Plan (IPP) dated February 13, 2009, at 3:45 p.m., revealed an objective which stated, "[the client] will participate in structural walks in the community/home five times per week with 80% accuracy." Review of the data sheet on September 1, 2009, at 2:00 p.m., revealed no documentation from the previous day. Interview with the Qualified Mental Retardation Professional (QMRP) at 11:00 AM confirmed that direct care staff did not document although the program was implemented.</p> <p>There was no evidence that the data had been collected in accordance with the IPP for the client, which was necessary for a functional assessment of the client's progress.</p> <p>2. During the entrance conference on September 1, 2009, beginning at 11:45 a.m., revealed Client #2 did not have a Behavior Support Plan (BSP) however the client did have a toileting schedule protocol. On September 1, 2009, at 5:30 p.m., Client #2 was observed wearing adult protective undergarments (APU's). Interview with the Qualified Mental Retardation Professional (QMRP) on September 2, 2009, at 10:30 a.m.,</p>	W 252 1&2	<p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p>	9-4-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 252	Continue from page 4 indicated that the client's toileting schedule should be implemented upon the client's wake-up. Further interview with the House Manager revealed that the client gets up around 5:30 - 6:00 a.m. Review of the data collection sheet on September 2, 2009 at approximately 2:00 p.m., revealed no documentation on the morning of September 2, 2009.	W 252		
W 255	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Review of Client #3's IPP dated September 12, 2008, revealed a program objective which stated, "given verbal prompts, [the client] will count from</p>	W 255	<p>Client #3's IPP program was reviewed and revised by the interdisciplinary team on 9-11-09 (Client #3's IPP review date was already schedule for 9-11-09 which is the date for his ISP.)</p> <p>Q.M.R.P was retrained by the Program Manager to ensure that all programs are revised whenever an individual consistently performs a program at 100% independence for 6 months. Also Program Manager will monitor above on quarterly basis.</p>	9-11-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003	
(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 255	Continued From page 5 one to one hundred with 50% independence. Review of the QMRP monthly notes from February 2009 through August 2009 revealed the client was independent 100% of the trials.	W 255		
W 261	There was no evidence that the QMRP revised the program. (count from 1 - 100). 483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on the committee, for one of the three clients included in the sample (Client #1) The finding includes: During the entrance conference on September 1, 2009, beginning on September 1, 2009, at 11:45 a.m., the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 received psychotropic medications for her maladaptive behaviors. Observations during the medication administration on September 1, 2009, at 6:12 p.m., Client #2 was observed being administered Geodon 60 mg and Ativan 1 mg.	W 261	The HRC meeting held on 5-12-09 approved a medication reduction plan for client #1. That is to reduce the Geodon from 80mg to 60mg PO QD that meeting was attended by two community representatives and the chairperson who is also from the community (with no ownership). The HRC meeting held on 8-25-09 had a community representative who is also the chairperson for the committee with no ownership with DC Health Care. The other two community members who are very regular and always present for meetings to discuss issues could not participate in the meeting due to transportation problem on (8-25-09) From now on DCHC will ensure that HRC meeting is attended by all members. If incase attendance is not complete, meeting will be rescheduled for another date and time. See Attachment B1 See Attachment B2	5-12-09 8-25-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 261	Continued From page 6 Review of the Human Rights Committee (HRC) meeting minutes was conducted on September 2, 2009, at 11:00 a.m. According to the HRC minutes dated August 28, 2009, Client #1's Behavior Support Plan (BSP) to include psychotropic medications (Geodon and Ativan) were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility at the time of the review and approval.	W 261		
W 356	453.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health for one of the three clients in the sample. (Client #2) The finding includes: Review of Client #2's medical record on September 2, 2009, at 4:00 p.m., revealed a dental consultation dated October 15, 2008. The dentist noted that the client received generalized scaling, prophylaxis with polish. The consult further noted the client should return in six months. Interview with the Qualified Mental Retardation Professional (QMRP) on September 2, 2009, at approximately 5:00 p.m., confirmed	W 356	Client #2 was scheduled for dental appointment on 6/30/09. However client # 2 did not make the appointment because he had gone on vacation from June 27 th to July 4 th 2009. Therefore his dental appointment was rescheduled for 9/7/09 (the earliest available date) However Client #2 did receive dental services on 9-7-09 as scheduled. QMRP will ensure that all individuals continue to receive their medical and dental services in a timely fashion.	9-7-09

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 356	Continued From page 7 the findings, verifying that the client had not returned at the specified time period as indicated. At the time of the survey, the facility failed to ensure Client #2 received timely dental services follow-up.	W 356		
W 381	483.460(l)(1) DRUG STORAGE AND RECORD KEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security, for one of the five clients in the facility. (Client #4) The finding includes: On September 1, 2009 at 7:06 p.m., the Licensed Practical Nurse (LPN) was observed to leave the medication closet door unlocked when he went to get Client #4 from another room. Further observation revealed the medication closet door was open and the Qualified Mental Retardation Professional (QMRP) and surveyor were left in the room. In an interview with medication nurse on September 1, 2009 after the medication administration at approximately 7:20 p.m., it was acknowledged the medication closet door was left unlocked when he went to retrieve Client #4.	W 381	All LPNs working with DCHC were retrained on 9-4-09 on DC Health Care's policy on medication administration with emphasis on storage, dispensing, disposal of medication and infection control. R.N and QMRP will monitor all LPN (medication nurses) for two weeks and then monthly and quarterly to ensure adherence to company's policy and procedure) (See Attachment C)	9-4-09
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection	W 455		

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

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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 455	<p>Continued From page 8 and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure proper infection control procedures, for one of the five clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>During the medication observation on September 1, 2009, at 6:04 p.m., Client #5 was observed punching four medications from each bubble pack of medication. One pill dropped onto the table. The client was observed picking up the pill and placing it into the medication cup. The client was observed pouring a cup of water and consuming the medications. The medication nurse was observed standing to the left of the client during the medication administration.</p> <p>There was no evidence that proper infection control procedures were implemented during the medication administration.</p>	W 455	<p>All LPNs working with DCHC were retrained on 9-4-09 on DC Health Care's policy on medication administration with emphasis on storage, dispensing, disposal of medication and infection control. R.N and QMRP will monitor all LPN (medication nurses) for two weeks and then monthly and quarterly to ensure adherence to company's policy and procedure)</p> <p>(See Attachment C)</p>	9-4-09
-------	--	-------	--	--------

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 14TH STREET, SE WASHINGTON, DC 20003
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from September 1, 2009 through September 3, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of one female resident and five male residents with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.</p>	1 000		
1 226	<p>3510.5(c) 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 observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for one of six residents residing in the facility. (Resident #5)</p> <p>The finding includes:</p> <p>During the medication observation on September 1, 2009, at 6:04 p.m., Resident #5 was observed punching four medications from each bubble pack of medication. One pill dropped onto the table. The resident was observed picking up the pill and placing it into the medication cup. The resident was observed pouring a cup of water</p>	1 226	<p>All LPNs working with DCHC were retrained on 9-4-09 on DC Health Care's policy on medication administration with emphasis on storage, dispensing, disposal of medication and infection control. R.N and QMRP will monitor all LPN (medication nurses) for two weeks and then monthly and quarterly to ensure adherence to company's policy and procedure)</p> <p>(See Attachment C)</p>	9-4-09

Health Regulation Administration

LABORATORY DIRECTOR'S OF HEALTH CARE PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *M. Mankatwan* TITLE: Deputy Director (X6) DATE: 9-30-09

STATE FORM 0LOB11 If continuation sheet 1 of 8

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003		
(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
1226	Continued From page 1 and consuming the medications. The medication nurse was observed standing to the left of the resident during the medication administration. There was no evidence that proper infection control procedures were implemented during the medication administration.	1226		
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Profession:() services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded ((3)HMRP) failed to ensure evaluations were conducted, for one of the three residents included in the sample. (Resident #2) The finding includes: Review of Resident #2's medical record on September 2, 2009, at 4:00 p.m., revealed a dental consultation dated October 15, 2008. The dentist noted that the resident received generalized scaling, prophylaxis with polish. Further noting the resident should return in six months. Interview with the Qualified Mental Retardation Professional (QMRP) on September 2, 2009, at approximately 5:00 p.m., confirmed the finding. At the time of the survey, the facility failed to ensure Resident #2 received timely dental services follow-up as specified.	1401	Client #2 was scheduled for dental appointment on 6/30/09. However client # 2 did not make the appointment because he had gone on vacation from June 27 th to July 4 th 2009. Therefore his dental appointment was rescheduled for 9/7/09 (the earliest available date) However Client #2 did receive dental services on 9-7-09 as scheduled. QMRP were ensure that all individuals continue to receive their medical and dental services in a timely fashion.	9-7-09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003		
(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	Continued From page 2	1422		
1422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP 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 observation, staff interview and record verification, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance was provided to residents in accordance with their individual Habilitation Plan (IHP), for one of the three residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>The facility failed to implement Resident #1's Individual Program Plan (IPP) as evidenced by the following:</p> <p>During the evening observation on September 1, 2009, at 4:10 p.m., a tray of snacks was observed in the kitchen refrigerator. The snacks consisted of 100 calorie cakes, pudding cups, fiber bars and peanut butter crackers. At 4:45 p.m., the House Manger was observed setting the tray of snack on the dining room table. At 5:11 p.m., Residents #1, #4, and #5 selected their choice of snack from the tray. At 5:15 p.m., the House Manager was observed assisting Resident #1 with passing out a snack to Resident #3. At 5:17 p.m., Resident #2 was given a choice of snack from the direct care staff.</p> <p>Review of the Resident #1's Individual Program Plan (IPP) on September 2, 2009, at approximately 9:35 a.m., revealed the resident had a program to pass out snacks to her peers that reflected the following steps:</p>	1422	<p>Staff were retrained on 9-4-09 on how to implement and document all individual program objectives. Program Manager and QMRP will ensure that staff is knowledgeable and can implement and document the IPP appropriately and in a timely manner through weekly and monthly quizzes or tests. Also the QMRP will monitor the program closely on a daily basis.</p> <p>See Attachment A</p>	9-4-09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 14TH STREET, SE WASHINGTON, DC 20003		
(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	Continued From page 3 - will place all snacks on a tray; - will individually pass out the snack to each one of her peers; and - will take tray to kitchen. Interview with the House Manger on September 2, 2009, at approximately 11:00 a.m., indicated that the resident required a lot of assistance to complete the task further acknowledging that Resident #1 was not given the opportunity to participate in the aforementioned program.	1422		
1424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident has successfully completed an objective identified in the IPP, for one of the three residents in the sample. (Resident #3) The finding includes: Review of Resident #3's IPP dated September 12, 2008, revealed a program objective which stated, "given verbal prompts, [the resident] will count from one to one hundred with 50% independence. Review of the QMRP monthly notes from February 2009 through August 2009	1424	Client #3's IPP program was reviewed and revised by the interdisciplinary team on 9-11-09 (Client #3's IPP review date was already schedule for 9-11-09 which is the date for his ISP.) Q.M.R.P was retrained by the Program Manager to ensure that all programs are revised whenever an individual consistently performs a program at 100% independence for 6 months. Also Program Manager will monitor above on quarterly basis.	9-11-09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003
---	--

(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
1424	Continued From page 4 revealed the resident was independent 100% of the trials. There was no evidence that the QMRP revised the program (count from 1 - 100).	1424		
1500	3523.1 RESIDENT'S RIGHTS 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 observation, staff interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137 (Rights of Mentally Retarded Citizens), this chapter, and other applicable District and Federal Laws, for one of the three residents included in the sample. (Resident #1) The finding includes: During the entrance conference on September 1, 2009, beginning at 11:45 a.m., the Qualified Mental Retardation Professional (QMRP) revealed that Resident #1 received psychotropic medications for her maladaptive behaviors. Observations during the medication administration on September 1, 2009, at 6:12 p.m., Resident #1 was observed being administered Geodon 60 mg and Ativan 1 mg. Review of the Human Rights Committee (HRC) meeting minutes was conducted on September 2, 2009, at 11:10 a.m. According to the HRC	1500	The HRC meeting held on 5-12-09 approved a medication reduction plan for client #1. That is to reduce the Geodon from 80mg to 60mg PO QD that meeting was attended by two community representatives and the chairperson who is also from the community (with no ownership). The HRC meeting held on 8-25-09 had a community representative who is also the chairperson for the committee with no ownership with DC Health Care. The other two community members who are very regular and always present for meetings to discuss issues could not participate in the meeting due to transportation problem on (8-25-09). From now on DCHC will ensure that HRC meeting is attended by all members. If incase attendance is not complete, meeting will be rescheduled for another date and time. See Attachment B1 See Attachment B2	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 901 14TH STREET, SE WASHINGTON, DC 20003		
(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
1500	Continued From page 5 minutes dated August 26, 2009, Resident #1's Behavior Support Plan (BSP) to include psychotropic medications (Geodon and Ativan) were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility.	1500		