

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

PRINTED: 09/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/18/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 14TH STREET, SE WASHINGTON, DC 20003</b>
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W 000	INITIAL COMMENTS  A recertification survey was conducted from September 17, 2013 through September 18, 2013. A sample of three clients was selected from a population of one female and five males with varying degrees of intellectual disabilities. The survey was initiated utilizing the fundamental survey process.  The findings of the survey were based on observations in the home and two day programs, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.	W 000		
W 189	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.] 483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff received effective training on securing clients wheelchairs when exiting the transportation van onto the wheelchair lift, for two of the three clients in the sample (Clients #2 and #4), failed to ensure staff was effectively trained to manage the provisions outlined in each client's mealtime protocol and nutritional assessment for one of the	W 189		

*Received*  
**USE AS ORIGINAL**  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Maura Cindain</i>	TITLE  <i>Deputy Director / D.C.H.C</i>	(X6) DATE  <i>10-1-13</i>
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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 189	<p>Continued From page 2</p> <p>2. Facility staff failed to ensure Client #1 was encouraged to drink liquids during their meal as recommended by the speech language pathologist (SLP) as evidenced by:</p> <p>a. Observations of the breakfast meal conducted on September 17, 2013, beginning at 7:35 a.m. revealed the following:</p> <p>7:36 a.m. - Client #1 was observed sitting upright at the dining table independently eating hominy grits from a high sided plate that was positioned on a riser. Sitting next to the client was direct support professional #2 (DSP #2).</p> <p>7:45 a.m. - Client #1 was observed eating pieces of a bran muffin with grape jelly.</p> <p>7:50 a.m. - DSP #2 was observed to open a container of low fat vanilla yogurt for Client #1 who then began to eat the yogurt slowly.</p> <p>8:00 a.m. - Client #1 was observed to drink approximately six ounces of low fat milk followed by six ounces of V8 splash juice and six ounces of decaffeinated coffee from a mug after consuming the entire meal. No difficulties in swallowing or coughing was noted during the breakfast meal.</p> <p>Review of Resident #1 medical record on September 17, 2013, beginning at 11:20 a.m., revealed the resident had diagnoses that included mild dysphagia, esophagitis and gastritis. Review of Client #1's SLP assessment and mealtime protocol dated April 2013, on the same day</p>	W 189		
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W 189	<p>Continued From page 3</p> <p>beginning at 12:08 p.m., revealed on the same day beginning at 12:08 p.m., revealed the resident was to alternate liquids/solids after eating two to three bites and then take sips of liquids.</p> <p>Interview with DSP #2 on September 18, 2013, at 9:12 a.m., confirmed that the DSP did not encourage Client #1 to drink liquids after eating two to three spoonful's of food. When asked, DSP #2 stated that they had training on Client #1's mealtime protocol earlier this same year.</p> <p>Review of the GHIID's staff in-service training record on September 17, 2013, at approximately 2:20 p.m., revealed all staff had received training on Client #1's mealtime protocol on April 7, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.</p> <p>3. Facility staff failed to ensure Client #1 was offered eight ounces of prune juice twice a day as recommended by the nutritionist as evidenced by:</p> <p>a. Observations of the breakfast and dinner meals on conducted on September 17, 2013, at approximately 7:35 a.m. and 6:40 p.m., respectively revealed the that the DSPs failed to offer Client #1 eight ounces of prune juice as recommended by the nutritionist.</p> <p>Review of Resident #1 medical record on September 17, 2013, at approximately 11:45 p.m., revealed the resident had diagnoses that included constipation. Review of Client #1's nutritional assessment dated May 2, 2013 and physician's order sheet (POS) dated September</p>	W 189			

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W 189	<p>Continued From page 4</p> <p>20013, on the same day revealed the resident was prescribed eight ounces of prune juice twice a day for bowel management.</p> <p>Interview with the qualified mental retardation professional (QIDP) on September 17, 2013, at 8:00 p.m., confirmed that the DSPs did not offer Client #1 eight ounces of prune juice as recommended by the nutritionist and the primary care physician (PCP). When asked, the QIDP stated that the staff had training on Client #1's nutritional provision for eight ounces of prune juice twice a day. Further interview revealed that the staff would be re-trained on the aforementioned nutritional provision.</p> <p>Review of the GHIID's staff in-service training record on September 17, 2013, at approximately 3:10 p.m., revealed all staff had received training on Client #1's on the aforementioned nutritional provision on April 7, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.</p> <p>4. The facility failed to ensure staff received effective and ongoing infection control training (hand washing) as evidenced below:</p> <p>On September 17, 2013, beginning at 6:35 p.m., DSP #5 was observed to open a loaf of wheat bread and remove several slices of the bread with their bare hands, touch the kitchen counter, open the door to the oven and place the slices of bread on a sheet of foil inside the oven without first washing their hands and putting on a pair of gloves.</p> <p>Interview with DSP #5 on the same day at approximately 7:30 p.m., revealed that they</p>	W 189			

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W 189	Continued From page 5 usually wash their hands and put on a pair of gloves before preparing food for the clients. Additionally, DSP #5 stated that they had training on infection control procedures but could not recall the date the training was completed.  Review of the in-service training records on September 17, 2013, beginning at 11:02 a.m., revealed that all staff including DSP #5 received training on universal precautions which included hand washing on February 23, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.	W 189			

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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from September 17, 2013 through September 18, 2013. A sample of three residents was selected from a population of one female and five males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 222	<p><b>3510.3 STAFF TRAINING</b></p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) the facility failed to ensure that staff received effective training on securing Residents wheelchairs when exiting the transportation van onto the wheelchair lift, for two of the three resident in the sample (Resident #2 and #4) and failed to ensure staff was effectively trained to manage the provisions outlined in each Resident's mealtime protocol and nutritional assessment for one of the three Residents in the sample (Resident #2).</p> <p>The findings include:</p>	1 222		

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

*Mamata Tindani*

*Deputy Director/D.C.H.C*

*10-1-13*

6899

MZBY11

If continuation sheet 1 of 7

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I 222	<p>Continued From page 1</p> <p>1. On September 17, 2013, at 4:46 p.m., observations revealed direct support professional (DSP) #1 assisted Resident #2, who was in a wheelchair onto the wheelchair lift from the van. The staff then was observed to lower the Resident to the ground. The staff was not observed to engage the wheelchair brakes. A similar observation was made for Resident #4.</p> <p>Interview with DSP #1 on September 14, 2013, at approximately 6:00 p.m., revealed that securing the wheelchair brakes after placing the resident's on the wheelchair lift was a standard procedure. When asked, DSP #1 stated that they did not secure Resident #2's and Resident #4's wheelchair brakes while lowering the wheelchairs down to the ground. DSP #1 then stated that he had received training on securing Residents wheelchairs within the past year.</p> <p>Review of the staff in-service training records on September 18, 2013, at 10:40 a.m., revealed that on August 29, 2013, all staff including DSP #1, received training on wheelchair security. However, observations on September 17, 2013, revealed training was not effective.</p> <p>2. Facility staff failed to ensure Resident #1 was encouraged to drink liquids during their meal as recommended by the speech language pathologist (SLP) as evidenced by:</p> <p>a. Observations of the breakfast meal conducted on September 17, 2013, beginning at 7:35 a.m. revealed the following:</p> <p>7:36 a.m. - Resident #1 was observed sitting</p>	I 222 1,2,3,4	<p>The staff was retrained on:</p> <p>a) Universal precautions on 09/17/13. b) Meal time protocols on 09/18/13 c) Wheelchair operation on 09/19/13. (See attachment A, B, C)</p> <p>These intense trainings included practical demonstrations, role play and questions and answers sessions.</p> <p>The QIDP and Program Manager will ensure all staff are knowledgeable in all areas by conducting daily monitoring on all shifts for one month and then weekly monitoring for six months.</p>	09/17/13 09/18/13 09/19/13

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I 222	<p>Continued From page 2</p> <p>upright at the dining table independently eating hominy grits from a high sided plate that was positioned on a riser. Sitting next to the Resident was direct support professional #2 (DSP #2).</p> <p>7:45 a.m. - Resident #1 was observed eating pieces of a bran muffin with grape jelly.</p> <p>7:50 a.m. - DSP #2 was observed to open a container of low fat vanilla yogurt for Resident #1 who then began to eat the yogurt slowly.</p> <p>8:00 a.m. - Resident #1 was observed to drink approximately six ounces of low fat milk followed by six ounces of V8 splash juice and six ounces of decaffeinated coffee from a mug after consuming the entire meal. No difficulties in swallowing or coughing was noted during the breakfast meal.</p> <p>Review of Resident #1 medical record on September 17, 2013, beginning at 11:20 a.m., revealed the resident had diagnoses that included mild dysphagia, esophagitis and gastritis. Review of Resident #1's SLP assessment and mealtime protocol dated April 2013, on the same day beginning at 12:08 p.m., revealed on the same day beginning at 12:08 p.m., revealed the resident was to alternate liquids/solids after eating two to three bites and then take sips of liquids.</p> <p>Interview with DSP #2 on September 18, 2013, at 9:12 a.m., confirmed that the DSP did not encourage Resident #1 to drink liquids after eating two to three spoonful's of food. When asked, DSP #2 stated that they had training on Resident #1's mealtime protocol earlier this same</p>	I 222		

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I 222	<p>Continued From page 3</p> <p>year.</p> <p>Review of the GHIID's staff in-service training record on September 17, 2013, at approximately 2:20 p.m., revealed all staff had received training on Resident #1's mealtime protocol on April 7, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.</p> <p>3. Facility staff failed to ensure Resident #1 was offered eight ounces of prune juice twice a day as recommended by the nutritionist as evidenced by:</p> <p>a. Observations of the breakfast and dinner meals on conducted on September 17, 2013, at approximately 7:35 a.m. and 6:40 p.m., respectively revealed the that the DSPs failed to offer Resident #1 eight ounces of prune juice as recommended by the nutritionist.</p> <p>Review of Resident #1 medical record on September 17, 2013, at approximately 11:45 p.m., revealed the resident had diagnoses that included constipation. Review of Resident #1's nutritional assessment dated May 2, 2013 and physician's order sheet (POS) dated September 20013, on the same day revealed the resident was prescribed eight ounces of prune juice twice a day for bowel management.</p> <p>Interview with the qualified mental retardation professional (QIDP) on September 17, 2013, at 8:00 p.m., confirmed that the DSPs did not offer Resident #1 eight ounces of prune juice as recommended by the nutritionist and the primary</p>	I 222		

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I 222	<p>Continued From page 4</p> <p>care physician (PCP). When asked, the QIDP stated that the staff had training on Resident #1's nutritional provision for eight ounces of prune juice twice a day. Further interview revealed that the staff would be re-trained on the aforementioned nutritional provision.</p> <p>Review of the GHIID's staff in-service training record on September 17, 2013, at approximately 3:10 p.m., revealed all staff had received training on Resident #1's on the aforementioned nutritional provision on April 7, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.</p> <p>4. The facility failed to ensure staff received effective and ongoing infection control training (hand washing) as evidenced below:</p> <p>On September 17, 2013, beginning at 6:35 p.m., DSP #5 was observed to open a loaf of wheat bread and remove several slices of the bread with their bare hands, touch the kitchen counter, open the door to the oven and place the slices of bread on a sheet of foil inside the oven without first washing their hands and putting on a pair of gloves.</p> <p>Interview with DSP #5 on the same day at approximately 7:30 p.m., revealed that they usually wash their hands and put on a pair of gloves before preparing food for the Residents. Additionally, DSP #5 stated that they had training on infection control procedures but could not recall the date the training was completed.</p>	I 222		

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I 222	Continued From page 5  Review of the in-service training records on September 17, 2013, beginning at 11:02 a.m., revealed that all staff including DSP #5 received training on universal precautions which included hand washing on February 23, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.	I 222		
I 226	3510.5(c) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure each staff was effectively trained on universal precautions (hand washing) to avoid sources and transmission of infection, for six of six of residents in the facility. (Resident #1, #2, #3, #4, #5 and #6)  The finding includes:  The GHIID failed to ensure staff received effective and ongoing infection control training (hand washing) as evidenced below:  On September 17, 2013, beginning at 6:35 p.m., DSP #5 was observed to open a loaf of wheat bread and remove several slices of the bread with their bare hands, touch the kitchen counter, open the door to the oven and place the slices of bread on a sheet of foil inside the oven without first washing their hands and putting on a pair of gloves.	I 226	The staff was retrained on Universal precautions on 09/17/13. (See attachment C)  These intense trainings included practical demonstrations, role play and questions and answers sessions.	09/17/13

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I 226	<p>Continued From page 6</p> <p>Interview with DSP #5 on the same day at approximately 7:30 p.m., revealed that they usually wash their hands and put on a pair of gloves before preparing food for the residents. Additionally, DSP #5 stated that they had training on infection control procedures but could not recall the date the training was completed.</p> <p>Review of the in-service training records on September 17, 2013, beginning at 11:02 a.m., revealed that all staff including DSP #5 received training on universal precautions which included hand washing on February 23, 2013. Observations on September 17, 2013, however, revealed the training had not been effective.</p>	I 226	<p>The QIDP and Program Manager will ensure all staff are knowledgeable in all areas by conducting daily monitoring on all shifts for one month and then weekly monitoring for six months.</p>	