

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

PRINTED: 06/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2013
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from June 13, 2013 through June 14, 2013. A sample of three clients was selected from a population of six males with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client 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> <p>There were no federal deficiencies identified.</p>	W 000			

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

TITLE

(X6) DATE

Mamta Tewari

Deputy Director / D.C.H.C

7/1/13

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.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2013
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019		
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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from June 13, 2013 through June 14, 2013. A sample of three residents was selected from a resident population of six men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, 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>	I 000		
I 091	<p>3504.2 HOUSEKEEPING</p> <p>Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used.</p> <p>This Statute is not met as evidenced by: Based on observations and interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure maintenance equipment (wheelchair lift seatbelt) was properly maintained and appropriate to the function for which it is to be used, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The finding includes:</p> <p>The GHIID failed to ensure the transportation van wheelchair lift was properly maintained and appropriate to the function for which it was to be</p>	I 091		

Health Regulation & Licensing Administration

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

TITLE

Deputy Director/D.C.H.C
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(X6) DATE

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I 091	<p>Continued From page 1</p> <p>used, as evidenced below:</p> <p>On June 13, 2013, at 8:27 a.m., Resident #3 was observed sitting in his custom molded wheelchair watching television in the living room. At 8:37 a.m., Staff #1 transported Resident #3 to the transportation van, placed the resident onto the van wheelchair lift and locked the brakes on the wheelchair. A few seconds later, the client was lifted up using the wheelchair van lift. The house manager (HM1) was observed standing directly beside the wheelchair lift as Resident #3 was lifted up. The wheelchair lift seatbelt that was attached to the wheelchair lift, was not used to secure Resident #3's wheelchair as the wheelchair was lifted up using the wheelchair lift. At 8:41 a.m., interview with HM1 revealed that the wheelchair lift seatbelt was not used because the seatbelt was broken. When asked, HM1 stated that the seatbelt was broken on June 12, 2013, and would be repaired on June 13, 2013.</p> <p>Observations conducted on June 14, 2013, at approximately 2:40 p.m., revealed the wheelchair seatbelt was still broken. A second interview conducted with HM1 on the same day at approximately 2:50 p.m. confirmed that the wheelchair lift seatbelt had not been repaired, as previously stated on June 13, 2013.</p>	I 091	<p>Wheelchair lift seat belt on the facility van was replaced on 06/28/13</p> <p>(See attachment)</p> <p>The QIDP and House Manager will check all equipment on a weekly basis for 6 weeks and then monthly to ensure that all equipment are in good working condition.</p>	06/28/13