

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE 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 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from January 10, 2013 through January 11, 2013. A sampling of three residents was selected from a population of six men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with residents, a guardian and family member, 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> <p>No deficiencies were cited.</p>	W 000	<p>March 8/13</p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	

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

Erney Stephen

TITLE

President

(X6) DATE

3/8/13

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.

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	<p>1000: INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 10, 2013 through January 11, 2013. A sampling of three residents was selected from a 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 three day programs, interviews with residents, a guardian and family member, 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>	1000		
	<p>1090: 3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for individuals with intellectual disabilities (GHID) was maintained in a safe and orderly manner for one of the six residents in the facility. (Resident #2)</p> <p>The findings include:</p> <p>On January 11, 2013, at 1:42 p.m., the house manager (Staff #2) and the qualified intellectual</p>	1090		

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Erney Stephen

TITLE *President*

(X8) DATE *3/8/13*

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1090	<p>Continued From page 1</p> <p>disabilities professional (QIDP, Staff #1) accompanied the surveyor through the facility's environment to conduct observations.</p> <p>1. The facility failed to ensure that Resident #2 was provided with a comfortable mattress, as evidenced below:</p> <p>On January 11, 2013, at 1:54 p.m., while checking Resident #2's bed, the surveyor observed that the springs in the queen size mattress were easily palpable through the bed sheet.</p> <p>Interview with the QIDP (Staff #1) on January 11, 2013, at 1:54 p.m., indicated that the mattress was purchased for Resident #2, approximately three years prior to the survey and should still be comfortable for the individual. Continued discussion with the QIDP (Staff #1) and also the house manager (Staff #2) indicated that Resident #2 likes to jump in his bed, which may have caused the padding over the springs to become worn.</p> <p>Interview with the program director (Staff #7) during the exit conference revealed that the condition of Resident #2's mattress had not been reported and that the mattress would be replaced.</p> <p>At the time of the survey, there was no evidence that Resident #2 was provided a comfortable mattress for his bed.</p> <p>2. On January 11, 2013, at 2:13 p.m., observation of the ironing board revealed that the legs were unstable and the ironing board cover was heavily stained and worn. The house manager (Staff #2) acknowledged that the ironing board was in poor repair and in need of replacement.</p>	1090	<p>1. Client # 2's mattress was replaced with a new one on January 14th 2013. The QIDP received in-service training on 01/17/13 on inspecting client mattresses and the environment on a monthly basis and informing the Program Manager in a timely manner of any replacement/repair or any other issue.</p> <p>(See Attachment "A1" & "A2")</p> <p>2. Ironing board was replaced on 01/17/13. QIDP received training on 01/17/13 on monthly inspection of environment and timely response to office.</p> <p>(See Attachment "A1")</p>	<p>01/14/13</p> <p>01/17/13</p>
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I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the group home for individuals with intellectual disabilities (GHID) failed to ensure that all employees had completed health certificates on file, for 1 of the 10 direct support staff. (Staff #4)</p> <p>The finding includes:</p> <p>On January 11, 2013, beginning at 11:30 a.m., review of the personnel records revealed a health certificate for Staff #3. Further review of that staff member's file revealed Staff #4 had a tuberculosis screening on March 30, 2012, however there was no evidence of the result of the test.</p> <p>Interview with the human resource director (Staff #3) at approximately 12:00 p.m. revealed that he will obtain the results of the tuberculosis test from Staff #4.</p>	I 206	<p>A copy of the Health Certificate for Staff #4 was obtained with TB screening. HR Director will review personnel files monthly to ensure that all required documents are obtained timely. (see attachment "B")</p>	01/17/13
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid.</p>	I 227		

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I 227	Continued From page 3 cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to have on file for review current training in cardiopulmonary resuscitation (CPR), for one of four nurses. (Staff #4) The finding includes: Review of the personnel records on January 11, 2012, beginning at 11:30 a.m., revealed the GHIID failed to have available for review a current CPR certification for Staff #4. This was confirmed by the human resource director (Staff #3) on the same day at approximately 12:15 p.m.	I 227		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure a centralized file was maintained and made available for inspection and review by authorized representatives of the regulatory agency for three of three residents in the sample. (Residents #1, #2, #3) The findings include:	I 261	Current CPR Certification for staff #4 was obtained. HR Director will review personnel files monthly to ensure all required documents are obtained timely. (See Attachment "C")	01/17/13

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1261	Continued From page 4 The GHID failed to ensure current records of interdisciplinary review of behavior protocols were maintained at the facility for Residents #1, #2, and #3. During the entrance conference on January 10, 2013, at 9:17 a.m., the qualified intellectual disabilities professional (QIDP, Staff #1) revealed that four of the six residents in the facility were prescribed medications to manage their behaviors, and had behavior support plans. Further discussion with the QIDP (Staff #1) revealed that the team conducted interdisciplinary reviews of the individuals' behavioral protocols and that the reports would be provided to the surveyors for review. Observation of the medication administration on January 10, 2013, beginning at 5:05 p.m., revealed the following medications were given: a. Resident #1: Divalproex SQ 500 milligrams, Olanzapine 5 milligrams, and Quetiapine Fumarate 200 milligrams; b. Resident #2: Olanzapine 10 milligrams, 2 tabs (20 milligrams), Quetiapine Fumarate 200 milligrams; c. Resident #3: Clonazepam 1 milligrams, Divalproex SQ 500 milligrams, Haloperidol 2 milligrams; On January 10, 2013, beginning at 5:05 p.m., interview with Staff #4, the licensed practical nurse who administered the medication, revealed that the aforementioned medications were prescribed to manage the residents' behaviors. Staff #4 indicated that Resident #2 also was prescribed Paxil 20 milligrams in the morning for behavior. This was confirmed by the review of	1261		

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1261	<p>Continued From page 5</p> <p>records on January 10, 2013, at 6:08 p.m. Further record review on January 11, 2013, beginning at 12:47 p.m., revealed that the aforementioned individuals also had behavior support plans that were implemented.</p> <p>On January 11, 2013, at 2:57 p.m., continued interview with the QIDP (Staff #1) revealed that in accordance with the facility's practice, each month the psychiatrist evaluated the individuals and their behavior medications. The QIDP (Staff #1) further revealed that the interdisciplinary team had convened every three months to review Resident #1, #2, and #3's behavior protocols (medications and behavioral progress), the forms were completed, and taken to the administrative office to be reviewed and signed by the psychiatrist. According to the QIDP (Staff #1), the documents had not been returned to the facility to be filed in the residents' records, and therefore were not available for review during the survey.</p> <p>On January 11, 2013, at 3:05 p.m., record review, revealed that the last team reviews of the behavioral protocols were dated February 21, 2012, for Residents #2 and #3. The review of Resident #3's record revealed he was admitted to the facility on September 1, 2012, and no record of the team's review of his behavioral protocol was included in his record.</p> <p>At the time of the survey, the facility failed to ensure records were maintained in a centralized file and provided for timely review by the authorized regulatory agency.</p>	1261	<p>Team review of psychotropic medication for Client # 1, #2 and #3 were filed on January 15th 2013. The review reports filed for Client #1 and #2 are dated 05/14/12, 08/16/12 and 11/27/12. Client #3 had review reports dated 11/27/12 filed. Admission date of Client #3 was 09/01/12. QIDP received in-service training to ensure that all reports are filed in a timely manner.</p> <p>(See attachments D1, D2, D3, D4, D5, D6, D7 (3 pages each and D8)</p>	01/15/13