

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/09/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 |
|--|---|

| | | | | |
|--------------------|--|---------------|---|----------------------|
| (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 November 8, 2012 through November 9, 2012. A sample of three clients was selected from a population of four women and two men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with clients, two guardians, 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> | W 000 | <p><i>Received 12/18/12</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p> | |
| W 369 | <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for three of the three clients in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>1. During the morning medication administration, the licensed practical nurse (Staff #3) failed to administer medications timely as follows:</p> | W 369 | | |

| | | |
|---|-------------------------------|---------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lorrey Shyker</i> | TITLE <i>President</i> | (X6) DATE <i>12-7-12</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: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/09/2012 |
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 369 | <p>Continued From page 1</p> <p>a. Observation of the medication administration on November 8, 2012, at 8:30 a.m., the licensed practical nurse (Staff #3) assisted Client #3 with administering her medications. The medications consisted of Norvasc, Vitamin C, Aspirin, Calcium, Ibuprofen, Prilosec, and a Multi-Vitamin.</p> <p>On November 8, 2012, at approximately 10:15 a.m., review of the client's medication administration record (MAR) and physician orders (POS) dated November 1, 2012, revealed the aforementioned medications were prescribed for 7:00 a.m.</p> <p>b. Observation of the medication administration on November 8, 2012, at 9:08 a.m., revealed the licensed practical nurse (Staff #3) was looking for his stethoscope to take the client's blood pressure. At 9:38 a.m., the licensed practical nurse (Staff #3) used a digital blood pressure machine to take Client #2's blood pressure. When asked, the licensed practical nurse (Staff #3) stated that the digital blood pressure machine "reads error sometimes". Therefore he wanted to use his stethoscope to read the clients blood pressure instead. At 9:40 a.m., the LPN (Staff #3) assisted Client #2 with administering his Os-Cal medication.</p> <p>On November 8, 2012, at approximately 10:30 a.m., review of the client's MAR and POS dated November 1, 2012, revealed the aforementioned medication was prescribed for 7:00 a.m.</p> <p>c. Observation of the medication administration on November 8, 2012, beginning at 9:47 a.m., the licensed practical nurse (Staff #3) assisted Client</p> | W 369 | <p>1-a,b,c. An in-service training was done on 11/28/12 with nurses regarding the importance of time line for medication administration (1 hour before and 1 hour after of assigned time). (See attachment #1)</p> <p>b. Each facility is equipped with a functioning electronic medical blood pressure machine and stethoscope etc. Equipment will be checked weekly and replaced and/or repaired as needed by assigned RN's.</p> <p>c. Infection control was reviewed and discussed at an in-service training on 11/28/12. Additionally, Infection control in-service is completed quarterly with nurses.</p> | <p>11/28/12</p> <p>11/28/12</p> <p>11/28/12</p> |

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/09/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 |
|--|---|

| (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 369 | <p>Continued From page 2</p> <p>#1 with administering his medications. The medications consisted of Albuterol Sulfate, Pulmicort, Antacid, Tegretol, Claritin, Phenobarbital, Priliosc, Flomax, Therotabs, Vitamin D, Azelastine, Nasacort and Artificial Tears.</p> <p>On November 8, 2012, at approximately 10:30 a.m., review of the client's MAR and POS dated November 1, 2012, revealed the aforementioned medications were prescribed for 7:00 a.m.</p> <p>On November 8, 2012, at 9:55 a.m., interview with the licensed practical nurse (Staff #3) revealed that he uses a stethoscope that is kept in the medication cabinet to take the client's blood pressure. However, time was taken as he tried to locate them.</p> <p>2. During the medication administration, the licensed practical nurse (Staff #3) failed to prompt Client #1 to administer the correct dosage.</p> <p>Observation of the medication administration on November 8, 2012, at 9:48 a.m., revealed the licensed practical nurse (Staff #3) handed Client #1 his Azelastine nasal spray. The client then administered three sprays in each nostril without verbal prompting.</p> <p>On November 8, 2012, at approximately 10:30 a.m., review of the client's MAR and current POS dated November 1, 2012, revealed an order to administer Azelastine nasal spray for asthma. Continued review revealed to pump two sprays in each nostril twice a day.</p> <p>Interview with the licensed practical nurse (Staff</p> | W 369 | <p>2. An in-service was completed with agency nurses on 11/28/12 regarding administration of medication. Medications to be administered on time (meeting the time line). Individuals who are participating in self med programs need to be monitored closely/carefully to avoid any medication error. Proper help & prompting to be done by assigned medication nurse. Unannounced monitoring during med pass to be done by agency RN's twice/month to ensure the above. On going training to medication nurses will be done by facility RN's. (See attachment 1)</p> | 11/28/12 |
|-------|--|-------|---|----------|

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/09/2012 |
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 369 | Continued From page 3 #3) at 10:31 a.m., confirmed that Client #1 administered three sprays of the aforementioned medication instead of two sprays. | W 369 | | | |
| W 436 | 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, 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 observation, interview and record review, the facility failed to ensure adaptive equipment identified by the interdisciplinary team as needed by the clients, was maintained in good repair for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure the wheelchair of Client #3 was maintained in good repair, as evidenced below: Observation on November 8, 2012, at approximately 8:45 a.m., revealed Client #3's wheelchair was missing the left wheelchair anti-tipper. The left armrest was taped at the front and back with blue tape and the right armrest was loose. Continued observation revealed the foot straps were not secure and dragged on the floor. Interview with the qualified intellectual disabilities professional (Staff #1) on November 9, 2012, at | W 436 | 1. Client # 3's wheelchair was repaired and the missing parts were replaced on 11/09/12. In-service training was conducted by Program Manager on 11/10/12 on the proper documentation of all adaptive equipment to include repairs to ensure that equipment is maintained in good repair at all times. The QIDP and House Manager will continue to monitor the facility to ensure that all adaptive equipment is maintained and kept in good repair. Program manager to monitor monthly for 3 months. (Attachment #2a and #2b) | 11/09/12 | |

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/09/2012 |
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 4 approximately 1:00 p.m., confirmed the aforementioned findings. Continued interview revealed she was not aware of when each damage occurred. 2. The facility failed to ensure the clients orthopedic shoes were maintained in good repair, as evidenced below: Observation on November 8, 2012, at 8:29 a.m., revealed Client #1 and #3 was observed wearing worn orthopedic shoes as they sat in their living room. Interview with the qualified intellectual disabilities professional (Staff #1) revealed the client's receives one orthopedic shoe every year. Further interview revealed that there were no record verification or adaptive equipments maintenance form available at the time of survey. | W 436 | 2. Client # 1 & 2's orthopedic shoes were obtained on 12/28/11 and 02/06/12 respectively. The insurance (medicaid) provides only one pair of shoes annually. The appointments for the next replacement pair have been made for 12/19/12. New high top supportive shoes were provided to Client#1 and #2 while shoes are repaired and to be rotated with new pairs which will be obtained at appointments. DDS Service Coordinator has been requested to pursue funds through DDS for a 2nd pair of new custom molded shoes to be purchase for Client #1 and #2. Program Manager to monitor status and ensure that orthopedic shoes are obtained. The QIDP and House Manager will continue to monitor adaptive equipment to ensure that it is kept and maintained good repairs at all times. | 12-19-12 | |
| 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 quarterly on all shifts for six of the six residents residing in the GHPID. (Residents #1, #2, #3, #4, #5 and #6) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On November 9, 2012, at 10:30 a.m., interview with the qualified intellectual disabilities | W 440 | All Staff at facility have been trained to conduct the fire drills for all the residents #1,#2,#3,#4,#5,#6 for all shifts one time per month, on 11/10/12. The QIDP and Program Manager will monitor the facilities to ensure that fire drills are conducted by every shift weekday+ weekend as well as night and day shift. (See attachment #3) | 11-10-12 | |

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/09/2012 |
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 440 | Continued From page 5 professional (Staff #1) revealed that there were three designated shifts (6:30 a.m. - 10:30 a.m.; 2:30 p.m. - 10:30 p.m.; and 10:30 p.m. - 6:30 a.m.), Monday through Friday and three designated shifts (6:30 a.m. - 2:30 p.m.; 2:30 p.m. - 10:30 p.m.; and 10:30 p.m. - 6:30 a.m.) for Saturday and Sunday. Review of the facility's fire drill records on November 9, 2012, beginning 10:31 a.m. revealed that no drills were held during the weekday shift at 10:30 p.m. - 6:30 a.m. from July 2012 through September 2012. Continued interview with the qualified intellectual disabilities professional (Staff #1) verified that there were no evidence fire drills were conducted during the aforementioned timeframe during the time of survey. | W 440 | | | |

Health Regulation & Licensing Administration

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0204 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/09/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 |
|--|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

I 000 INITIAL COMMENTS

A licensure survey was conducted from November 8, 2012 through November 9, 2012. A sample of three clients was selected from a population of four women and two men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and three day programs, interviews with clients, two guardians, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

I 000

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 group home for persons with intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for six of the six residents residing in the GHPID. (Residents #1, #2, #3, #4, #5 and #6)

The finding includes:

The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On November 9, 2012, at 10:30 a.m., interview

I 135

All Staff at facility have been trained to conduct the fire drills for all the residents #1,#2,#3,#4,#5,#6 for all shifts four times a year, on 11/10/12. The QIDP and Program Manager will monitor the facilities to ensure

11-10-12

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

TITLE *President* (X6) DATE *12-7-12*

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0204 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/09/2012 |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 |
| I 135 | Continued From page 1 with the qualified intellectual disabilities professional (Staff #1) revealed that there were three designated shifts (6:30 a.m. - 10:30 a.m.; 2:30 p.m. - 10:30 p.m.; and 10:30 p.m. - 6:30 a.m.), Monday through Friday and three designated shifts (6:30 a.m. - 2:30 p.m.; 2:30 p.m. - 10:30 p.m.; and 10:30 p.m. - 6:30 a.m.) for Saturday and Sunday. Review of the GHPID's fire drill records on November 9, 2012, beginning 10:31 a.m. revealed that no drills were held during the weekday shift at 10:30 p.m. - 6:30 a.m. from July 2012 through September 2012. Continued interview with the qualified intellectual disabilities professional (Staff #1) verified that there were no evidence fire drills were conducted during the aforementioned timeframe during the time of survey. | I 135 | fire drills are conducted by every shift weekday +weekend as well as night and day shift. (See attachment #3) | |
| I 212 | 3509.9(d) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (d) Conviction for a sexual offense or violent crime. This Statute is not met as evidenced by: Based on interview and the review of employee records, the facility failed to obtain a criminal background check, that discloses the individual's criminal history in all jurisdictions where the individual has worked or resided with the previous seven (7) years for one of eight consultants. | I 212 | | |

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0204 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/09/2012 |
|--|---|---|--|--------------------|---|
| NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012 | | |
| (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 | |
| I 212 | Continued From page 2 (Staff #5) The finding includes: Review of the personnel files on November 9, 2012, beginning at 11:20 a.m., revealed that the facility failed to provide a police background check for Staff #5. Interview with Staff #4 revealed Staff #5 obtained a background check, but he was unable to provide evidence at the time of survey. | I 212 | The background check for consultant #5 was conducted on 12/07/12. DCHC will ensure that all consultants will obtain employment verification and background checks in a timely manner. (please see attachment #4 pages1-4) | 12-07-12 | |