

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/25/2014
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NAME OF PROVIDER OR SUPPLIER  D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 249 WALNUT STREET, NW WASHINGTON, DC 20012
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 27828 A recertification survey was conducted from April 23, 2014 through April 25, 2014. A sample of three clients was selected from a population of five men with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Qualified Intellectual Disabilities Professional - QIDP Individual Support Plan - ISP Individual Program Plan - IPP</p>	W 000	<p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p> <p>RECEIVED MAY 03 2014</p>	
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:</p>	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Maura Curran* Deputy Director D-C-NIC 5/29/14

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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PRINTED: 05/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 249	<p>Continued From page 1 Surveyor: 27828 Based on observation, interview, and record review, the facility staff failed to ensure each client's ambulation program was implemented, for one of the three sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>On April 23, 2014, at 4:52 p.m., when Client #2 arrived home from the day program, observations revealed DSP #1 escorted Client #2 into the facility as he sat in his wheelchair. At 5:00 p.m., DSP #1 escorted Client #2 in his wheelchair to the dining room table for a snack. At 5:17 p.m., DSP #1 and DSP #2 used a gaitbell to assist Client #2 as he walked approximately three steps from the wheelchair to the couch. At 6:00 p.m., DSP #2 escorted Client #2 in his wheelchair to receive his medication in the kitchen. At 7:06 p.m., DSP #1 assisted Client #2 in his wheelchair to the dining room table for dinner where the client remained until 7:45 p.m. Client #2 was not observed ambulating in the facility throughout the survey period.</p> <p>Review of Client #2's ISP records on April 24, 2014, at 2:46 p.m., revealed an IPP dated February 1, 2014. According to the IPP, the client had an objective that read;</p> <p>With physical assistance, the client will ambulate 4-5 laps around the living and dining room area daily.</p> <p>Interview with DSP #2 on April 24, 2014, at approximately 4:30 p.m. revealed Client #2 did not ambulate in the facility on April 23, 2014. According to DSP #2, he/she was not aware that there was a daily requirement for Client #2 to</p>	W 249	<p>An in-service training was completed on 04/26/14 for all the D.S.P's and House Managers by the Q.I.D.P and Program Manager regarding the implementation and documentation of IPP programs. The Q.I.D.P will monitor to make sure that programs are implemented &amp; documented. Q.I.D.P will check the above x2 weeks regularly then weekly. D.S.P's will be re-trained on a quarterly basis to emphasize the program. The Program Manager will check the above on her routine unannounced visit. See Attachment # 1</p>	04/26/14	

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W 249	Continued From page 2 ambulate. DSP #2 indicated the client was only required to participate with the aforementioned ambulation objective three times a week.  At the time of the survey, the facility failed to implement Client #2's ambulation program as recommended.	W 249		
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: Surveyor: 27828 Based on interview and record review, the facility failed to hold evacuation drills quarterly, for six of the six shifts of duty reviewed (Weekday 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.) and weekend (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.)  The finding includes:  On April 23, 2014, at 9:45 a.m., interview with the QIDP 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 April 23, 2014, beginning at 9:47 a.m., revealed that there was no evidence that drills were held during the 6:30 a.m. - 2:30 p.m., and 2:30 p.m. - 10:30 p.m., weekday and weekend shifts from October	W 440	An in-service training was completed for all the D.S.P's on 04/26/14 and House Manager by Q.I.D.P regarding the implementation of the fire drills on a monthly basis on all shifts and to completely document the fire drills forms. The Q.I.D.P and the House Manager will ensure that all the fire drills are conducted as outlined by D.C.H.C and the fire drill forms are completed correctly. Q.I.D.P and Program Manager will review during their visits to the facility.  See Attachment #2	04/26/14

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W 440	<p>Continued From page 3</p> <p>2013 through December 2013. Additionally, there was no evidence that drills were held during the 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., weekday shift from January 2014 through March 2014. Further review revealed no evidence that drills were held during the 6:30 a.m. - 2:30 p.m. and 2:30 p.m. - 10:30 p.m. weekend shifts from January 2014 through March 2014. Continued review of the fire drill records revealed that the facility failed to consistently document the specific time of day the drills were completed. The QIDP and the HM reviewed the fire drill reports on March 25, 2014, at 2:00 p.m. and confirmed that there was no evidence that drills were conducted during the aforementioned time periods and that staff failed to document the fire drill forms completely.</p> <p>At the time of the survey, the facility failed to provide evidence that fire drills were conducted at least quarterly for each shift of personnel.</p>	<p>W 440</p> <p>W 440</p>			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/25/2014</b>
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 27828 A licensure survey was conducted from April 23, 2014 through April 25, 2014. A sample of three residents was selected from a population of five men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Qualified Intellectual Disabilities Professional - QIDP Individual Support Plan - ISP Individual Program Plan - IPP</p>	1 000		
1 135	<p><b>3505.5 FIRE SAFETY</b></p> <p>Each GIMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Surveyor: 27828 Based on interview and record review, the facility failed to hold evacuation drills quarterly, for six of the six shifts of duty reviewed (Weekday 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.) and weekend (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.)</p>	1 135		

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mauritius TITLE: Deputy Director/D.C.H.C. (X6) DATE: 5/29/14

STATE FORM 8899 1LDX11 If continuation sheet 1 of 4

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/25/2014
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I 135	<p>Continued From page 1</p> <p>The finding includes:</p> <p>On April 23, 2014, at 9:45 a.m., interview with the QIDP 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.</p> <p>Review of the facility's fire drill records on April 23, 2014, beginning at 9:47 a.m., revealed that there was no evidence that drills were held during the 6:30 a.m. - 2:30 p.m., and 2:30 p.m. - 10:30 p.m., weekday and weekend shifts from October 2013 through December 2013. Additionally, there was no evidence that drills were held during the 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., weekday shift from January 2014 through March 2014. Further review revealed no evidence that drills were held during the 6:30 a.m. - 2:30 p.m. and 2:30 p.m. - 10:30 p.m. weekend shifts from January 2014 through March 2014. Continued review of the fire drill records revealed that the facility failed to consistently document the specific time of day the drills were completed. The QIDP and the HM reviewed the fire drill reports on March 25, 2014, at 2:00 p.m. and confirmed that there was no evidence that drills were conducted during the aforementioned time periods and that staff failed to document the fire drill forms completely.</p> <p>At the time of the survey, the facility failed to provide evidence that fire drills were conducted at least quarterly for each shift of personnel.</p>	I 135	<p>An in-service training was completed for all the D.S.P's on 04/26/14 and House Manager by Q.I.D.P regarding the implementation of the fire drills on a monthly basis on all shifts and to completely document the fire drills forms. The Q.I.D.P and the House Manager will ensure that all the fire drills are conducted as outlined by D.C.H.C and the fire drill forms are completed correctly. Q.I.D.P and Program Manager will review during their visits to the facility.</p> <p>See Attachment #2</p>	04/26/14

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1422	Continued From page 2	1422		
1422	<p><b>3521.3 HABILITATION AND TRAINING</b></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: Surveyor: 27828 Based on observation, interview and record review, the GHID staff failed to ensure each resident's ambulation program was implemented, for one of the three sampled resident. (Resident #2)</p> <p>The finding includes:</p> <p>On April 23, 2014, at 4:52 p.m., when Resident #2 arrived home from the day program, observations revealed DSP #1 escorted Resident #2 into the facility as he sat in his wheelchair. At 5:00 p.m., DSP #1 escorted Client #2 in his wheelchair to the dining room table for a snack. At 5:17 p.m., DSP #1 and DSP #2 used a gaitbelt to assist Resident#2 as he walked approximately three steps from the wheelchair to the couch. At 6:00 p.m., DSP #2 escorted Resident #2 in his wheelchair to receive his medication in the kitchen. At 7:06 p.m., DSP #1 assisted Resident #2 in his wheelchair to the dining room table for dinner where the client remained until 7:45 p.m. Resident #2 was not observed ambulating in the facility throughout the survey period</p> <p>Review of Client #2's ISP records on April 24, 2014, at 2:46 p.m., revealed an IPP dated February 1, 2014. According to the IPP, the client had an objective that read;</p> <p>With physical assistance, the client will ambulate 4-5 laps around the living and dining room area</p>	1422	<p>An in-service training was completed on 04/26/14 for all the D.S.P's and House Managers by the Q.I.D.P and Program Manager regarding the implementation and documentation of IPP programs. The Q.I.D.P will monitor to make sure that programs are implemented &amp; documented. Q.I.D.P will check the above x2 weeks regularly then weekly. D.S.P's will be re-trained on a quarterly basis to emphasize the program. The Program Manager will check the above on her routine unannounced visit. See Attachment # 1</p>	04/26/14

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I 422	<p>Continued From page 3</p> <p>daily.</p> <p>Interview with DSP #2 on April 24, 2014, at approximately 4:30 p.m. revealed Resident #2 did not ambulate in the facility on April 23, 2014. According to DSP #2, he/she was not aware that there was a daily requirement for Resident #2 to ambulate. DSP #2 indicated the client was only required to participate with the aforementioned ambulation objective three times a week.</p> <p>At the time of the survey, the facility failed to implement Resident #2's ambulation program as recommended.</p>	I 422		