

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

PRINTED: 07/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20012
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(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
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WV 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from July 8, 2013 through July 10, 2013. A sample of three clients was selected from a population of five males 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 two day programs, interviews with one client's medical guardian, 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>	WV 000		
W 340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to provide effective training on preventive health and hygiene measures (specifically hair grooming), for two of five clients residing in the facility (Clients #2 and #5)</p> <p>The finding includes:</p>	W 340	<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 Steph* TITLE: *President* (X6) DATE: *8/2/13*

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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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 07/10/2013
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20012
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W 340	<p>Continued From page 1</p> <p>On July 8, 2013, at approximately 8:40 a.m., a direct support staff (Staff #1) was observed brushing Client #2's hair with a blue brush. A moment later, the staff turned to Client #5 and began brushing his hair with the same brush. When asked by this surveyor if he had used the same brush with both clients, he replied "yes" and he left the room. He returned a moment later carrying a blue hair brush and continued brushing Client #5's hair.</p> <p>Review of the in-service training records on July 8, 2013, beginning at 3:30 p.m., revealed that all staff, including Staff #1 received training on grooming and personal hygiene on April 13, 2013. Observations earlier that day, however, revealed the training had not been effective.</p> <p>It should be noted that on July 9, 2013, at 3:05 p.m., Staff #2 facilitated a review of the five clients' personal hygiene kits. There was no brush observed in Client #2's hygiene kit and a brown hair brush was observed in Client #5's kit.</p>	W 340	<p>An in-service training was completed by the Program Manager on 07/08/13 regarding infection control for staff and individuals. All individuals have new brushes in their personal hygiene caddies. The QIDP will monitor daily for 7 days then on a weekly basis for 3 months to ensure each individual has the necessary grooming items in their personal hygiene caddies and they are used separately to ensure prevention and spread of germs from one to another.</p> <p>See attachment "A"</p>	07/08/13
W 368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of client records, the facility failed to ensure that clients' medications were administered in accordance with physician's orders, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p>	W 368		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20012
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(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
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W 368	<p>Continued From page 2</p> <p>The evening medication administration was observed on July 8, 2013, beginning at 5:04 p.m. At 6:25 p.m., review of Client #3's July 2013 medication administration record (MAR's) revealed the client had been administered Ativan 2 milligrams (mg) on July 2, 2013 prior to a dental appointment.</p> <p>On July 10, 2013, beginning at 10:35 a.m., review of Client #3's habilitation and medical records revealed the following:</p> <ul style="list-style-type: none"> - On July 18, 2012, the psychologist wrote a statement indicating that past desensitization training programs had been ineffective in addressing the client's anxiety with medical appointments. The psychologist recommended that Client #3 receive medication for sedation prior to future medical appointments. The interdisciplinary team had concurred with the recommendation. - The client's court-appointed medical guardian provided written consent for pre-sedation for eight medical appointments between July 27, 2012 and July 2, 2013. <p>Continued review of Client #3's medical records on July 10, 2013, beginning at 12:04 p.m., revealed that pre-sedation medication was not consistently administered in accordance with physician's orders (POS), as follows:</p>	W 368	<p>An in-service training with medication nurses was completed on 07/11/13 to ensure pre-medication prior to medical appointments is administered per the physician's order. After giving medication, proper documentation on M.A.R with date, time and vital signs are done. Also, control sheet is updated as well. The nurse in-charge will f/u on a monthly basis to ensure the implementation of the above.</p> <p>Resident #3 often refuses medical treatment, despite the administration of pre-sedation. The IDT will review the status of medical appointments and pre-sedation at Resident #3's ISP scheduled for 08/22/13 to determine what is most important for Resident#3 to complete in regards to medical appointments.</p> <p>(See attachment "B")</p>	07/11/13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20012
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W 368	<p>Continued From page 3</p> <p>1. According to a consultation report, Client #3 was uncooperative with the ophthalmologist on August 3, 2012, at 8:30 a.m., and the evaluation was not completed. The client's MAR reflected administration of Ativan 3 mg at 8:30 a.m. The order stated that he should receive pre-sedation 1 1/2 hours prior to the appointment.</p> <p>2. Another consultation report documented that Client #3 was uncooperative for an Ear, Nose, and Throat (ENT) appointment on December 21, 2012, at 2:40 p.m., and they were unable to complete the evaluation. The MAR reflected administration of Ativan 2 mg at 12:30 p.m. (2 hours 10 minutes earlier). The order, however, stated that he should receive pre-sedation 1 1/2 hours prior to the appointment.</p> <p>3. He was uncooperative with the neurologist on April 11, 2013, at 9:15 a.m., and the evaluation was not completed. The MAR reflected administration of Ativan 2 mg at 7:00 a.m. (2 hours 15 minutes earlier). The order stated that he should receive it 1 1/2 hours prior to the appointment.</p> <p>During the Exit conference on July 10, 2013, at approximately 3:30 a.m., the facility's nursing director (Staff #3) acknowledged that the aforementioned administration times were not in compliance with Client #3's POS. She suggested however, that the sedative effect of the medication would last beyond 1 1/2 hours following administration. A post-survey review of the online website www.rxdist.com revealed the</p>	W 368		
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W 368	<p>Continued From page 4</p> <p>following: "Ativan (lorazepam) is readily absorbed with an absolute bioavailability of 90 percent. Peak concentrations in plasma occur approximately 2 hours following administration."</p> <p>It should be noted that a dentist documented Client #3 was combative and did not receive services (evaluation and/or treatment) on June 4, 2013. The client's record failed to show evidence that sedation was ordered or sought prior to the June 4, 2013 appointment. By contrast, the client's November 2012 MAR reflected that he was administered Ativan 3 mg prior to a dental appointment on November 20, 2012, at which time he received prophylactic cleaning, polish and debridement on that day. When the failure to provide sedation on June 4, 2013 was raised at the Exit conference, no additional information was shared for clarification.</p>	W 368		
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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: 07/10/2013
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20012
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1000	INITIAL COMMENTS A licensure survey was conducted from July 8, 2013 through July 10, 2013. A sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident's medical guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1000		
1226	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 group home for individuals with intellectual disabilities (GHID) failed to provide effective training on preventive health and hygiene measures (specifically hair grooming), for two of five residents residing in the facility. (Residents #2 and #5) The finding includes: On July 8, 2013, at approximately 8:40 a.m., a direct support staff (Staff #1) was observed brushing Resident #2's hair with a blue brush. A	1226		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Gregory S. [Signature]

TITLE: President

(X6) DATE: 8/2/13

STATE FORM

D8E011

If continuation sheet 1 of 5

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0118	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, 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 226	Continued From page 1 moment later, the staff turned to Resident #5 and began brushing his hair with the same brush. When asked by this surveyor if he had used the same brush with both residents, he replied "yes" and he left the room. He returned a moment later carrying a blue hair brush and continued brushing Resident #5's hair. Review of the in-service training records on July 8, 2013, beginning at 3:30 p.m., revealed that all staff, including Staff #1 received training on grooming and personal hygiene on April 13, 2013. Observations earlier that day, however, revealed the training had not been effective. It should be noted that on July 9, 2013, at 3:05 p.m., Staff #2 facilitated a review of the five residents' personal hygiene kits. There was no brush observed in Resident #2's hygiene kit and a brown hair brush was observed in Resident #5's kit.	I 226	An in-service training was completed by the Program Manager on 07/08/13 regarding infection control for staff and individuals. All individuals have new brushes in their personal hygiene caddies. The QIDP will monitor daily for 7 days then on a weekly basis for 3 months to ensure each individual has the necessary grooming items in their personal hygiene caddies and they are used separately to ensure prevention and spread of germs from one to another. See attachment "A"	07/08/13
I 401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS. Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with Intellectual disabilities (GHID) failed to ensure the provision of nursing and dental services to meet the residents' assessed needs, for one of three residents in the sample. (Resident #3)	I 401		

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 07/10/2013
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, 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 401	<p>Continued From page 2</p> <p>The findings include:</p> <p>The GHID failed to ensure that nursing staff administered pre-sedation medication as ordered, to ensure Resident #3's compliance with medical appointments, as follows:</p> <p>The evening medication administration was observed on July 8, 2013, beginning at 5:04 p.m. At 6:25 p.m., review of Resident #3's July 2013 medication administration record (MAR's) revealed the resident had been administered Ativan 2 milligrams (mg) on July 2, 2013 prior to a dental appointment.</p> <p>On July 10, 2013, beginning at 10:35 a.m., review of Resident #3's habilitation and medical records revealed the following:</p> <ul style="list-style-type: none"> - On July 18, 2012, the psychologist wrote a statement indicating that past desensitization training programs had been ineffective in addressing the resident's anxiety with medical appointments. The psychologist recommended that Resident #3 receive medication for sedation prior to future medical appointments. The interdisciplinary team had concurred with the recommendation. - The resident's court-appointed medical guardian provided written consent for pre-sedation for eight medical appointments between July 27 2012 and July 2, 2013. <p>Continued review of Resident #3's medical records on July 10, 2013, beginning at 12:04 p.m., revealed that pre-sedation medication was</p>	I 401	<p>An in-service training with medication nurses was completed on 07/11/13 to ensure pre-medication prior to medical appointments is administered per the physician's order. After giving medication, proper documentation on M.A.R with date, time and vital signs are done. Also, the control sheet is updated as well. The nurse in-charge will f/u on a monthly basis to ensure the implementation of the above.</p> <p>Resident #3 often refuses medical treatment, despite the administration of pre-sedation. The IDT will review the status of medical appointments and pre-sedation at Resident #3's ISP scheduled for 08/22/13 to determine what is most important for Resident#3 to complete, in regards to medical appointments.</p> <p>(See attachment "B")</p>	07/11/13

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, 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 401	<p>Continued From page 3</p> <p>not consistently administered in accordance with physician's orders (POS), as follows:</p> <p>1. According to a consultation report, Resident #3 was uncooperative with the ophthalmologist on August 3, 2012, at 8:30 a.m., and the evaluation was not completed. The resident's MAR reflected administration of Ativan 3 mg at 8:30 a.m. The order stated that he should receive pre-sedation 1 1/2 hours prior to the appointment.</p> <p>2. Another consultation report documented that Resident #3 was uncooperative for an Ear, Nose, and Throat (ENT) appointment on December 21, 2012, at 2:40 p.m., and they were unable to complete the evaluation. The MAR reflected administration of Ativan 2 mg at 12:30 p.m. (2 hours 10 minutes earlier). The order, however, stated that he should receive pre-sedation 1 1/2 hours prior to the appointment.</p> <p>3. He was uncooperative with the neurologist on April 11, 2013, at 9:15 a.m., and the evaluation was not completed. The MAR reflected administration of Ativan 2 mg at 7:00 a.m. (2 hours 15 minutes earlier). The order stated that he should receive it 1 1/2 hours prior to the appointment.</p> <p>During the Exit conference on July 10, 2013, at approximately 3:30 a.m., the facility's nursing director (Staff #3) acknowledged that the aforementioned administration times were not in compliance with Resident #3's POS. She suggested however, that the sedative effect of the medication would last beyond 1 1/2 hours</p>	I 401		

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 243 WALNUT STREET, 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
1401	<p>Continued From page 4</p> <p>following administration. A post-survey review of the online website www.rxlist.com revealed the following: "Ativan (lorazepam) is readily absorbed with an absolute bioavailability of 90 percent. Peak concentrations in plasma occur approximately 2 hours following administration."</p> <p>4. Resident #3's dentist documented that he was combative and did not receive services (evaluation and/or treatment) on June 4, 2013. The resident's record failed to show evidence that sedation was ordered or sought prior to the June 4, 2013 appointment. By contrast, the resident's November 2012 MAR reflected that he was administered Ativan 3 mg prior to a dental appointment on November 20, 2012, at which time he received prophylactic cleaning, polish and debridement on that day. When the failure to provide sedation on June 4, 2013 was raised at the Exit conference, no additional information was shared for clarification.</p> <p>At the time of the survey, the GHIID failed to ensure Resident #3 received recommended supports, including pre-sedation, to elicit his cooperation during medical appointments.</p>	1401		