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

PRINTED: 05/21/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G057	A. BUILDING _____ B. WING _____	R 05/04/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	426 "Q" STREET, NW WASHINGTON, DC 20001

(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}	INITIAL COMMENTS This re-visit was conducted on May 2, 2007 through May 4, 2007. A new client sample was selected for the purpose of this survey. One of the clients in this sample was also identified and reviewed in the original sample. An extended survey was implemented due to the condition levels identified during the initial survey conducted March 22, 2007. The findings were derived from observations, interviews with the direct care staff and the Qualified Mental Retardation Professional, review of policies, training records for staff and medical personnel, review of incident report records, review of medical and clinical records (individual support plan, individual program plans, program documentation, and assessments. At the time of this revisit, the facility was found to be in substantial compliance in the areas of client protection and health care services. It was further identified that each standard level of active treatment services had been addressed and the facility had implemented and executed their proposed plan to address the focuse needs of one of the four clients in the sample.	{W 000}		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review the facility failed to ensure that all client program objectives were formulated to provide measurable indices of performance for one of four clients in the sample.	W 231		

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 MAY 30 A ~~8:58~~ After 5pm

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerry Stephen	President	5/30/07

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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W 231	Continued From page 1 The findings include: Objectives identified by client #7's June 29, 2007 IPP did not reflect criterion levels or identified levels of expected assistance. Client #7's IPP was reviewed on May 3, 2007 at 2:30 PM. a. According to client #7's individual program plan (IPP), the client had an objective which read "will have the opportunity to interact with opposite sex one time a monthly". b. Client # 7's IPP included an objective that read "will use a communications board to name and/or point to two activities. The objective was no written in measuable terms to determine client #7s' progress.	W 231	Client#7 had a Pre-ISP meeting on 05/11/07. All the IPP program were reviewed. A ISP meeting is scheduled for 06/12/07 and all the new IPP program will be implemented by 06/12/07. QMRP will make sure that all the identified objectives are written in measurable terms.	
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review of clients to include review of individual program plans (IPPs) and data collection documents, the facility failed to ensure that all clients' data collected yielded information relevant to making program decisions regarding the objectives. The finding includes:	W 252		

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W 252	Continued From page 2 The IPP and program documentation for client #7 was reviewed on May 3, 2007 at 10:00 AM. The results of this review revealed that the client had a program objective that read "with 25% independence, [the client] will get a CD player with ear phone and learn how to operate it". The documentation reviewed from January 2007 to April 2007 reflected that client #7 performed at 100% independence. However, the data sheet reflected the measurable task to be "will listen to music at his leisure time". Client #7 was observed being offered his CD player that he kept within reach. Although offered, client #7 refused to demonstrate if he could operated his CD player. Client #7 did comply with staff attempt to have him cut off the T.V. and turn on the community radio with verbal prompting and physical assistance. Staff interviewed on May 2, 2007 at 6:18 PM, stated that client #7 enjoys his CD player and is capable of operating it but will give it to staff for assistance when he is unable to get it to play. The progress of this objective could not be determined.	W 252	Client#7 had a Pre-ISP meeting on 05/11/07. All the IPP program were reviewed. A ISP meeting is scheduled for 06/12/07 and all the new IPP program will be implemented by 06/12/07. QMRP will make sure that all the identified objectives are written in measurable terms.	
{W 393}	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring	{W 393}		

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{W 393}	Continued From page 3 testing for one of four clients in the sample. (Client #3) The finding includes: Interview with the medication nurse on March 20, 2007 at approximately 5:45 PM, revealed that Client #3 has a diagnosis of diabetes. The medication nurse further revealed that the client provides a urine sample each morning to test his glucose level. Additionally, the medication nurse informed the surveyor that the client 's urine is tested for keytones and the test strips are used for this process. The test strips are dipped in the client's urine and are compared with a color chart on the test bottle for comparative reading. The medication nurse records the glucose level on the medication administration record, daily. Interview with the Qualified Mental Retardation Professional and and the Director March 22, 2007 at approximately 12:30 p.m. revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA).	{W 393}	Application for certificate of waiver under CLIA has been submitted. DCHC will secure CLIA as soon as the application gets processed by the state agency. DCHC will continue to follow up.	