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

PRINTED: 08/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G038		08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	47 QUINCY PLACE, 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 A recertification survey was conducted from August 11, 2008 through August 12, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients were selected from a population of six males with various disabilities. The findings of this survey were based on observations at the group home, three day programs, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports	W 000	Received 9/2/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: 1. The governing body failed to ensure that the agency's nursing staff failed to ensure nursing services in accordance with the agency nursing policy and procedures. [See W331]	W 104 1.	Please see the answer to W331	
	2. The governing body failed to ensure that the direct care staff implemented the Client Protection/Safety Policy as evidenced below: Observation on August 12, 2008 at approximately	2.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gymey Stephen
TITLE: President
(X6) DATE: 9/2/08

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 104	Continued From page 1 8:05 AM, revealed the direct care staff members were observed to escort clients (Clients #1, #2, #3, #4, #5, and #6). The clients occupies all four rows of seats on the van. At approximately 8:15 AM the driver of the van (house manager) drove off the premise in route to the clients day programs. At no time prior to the van leaving the facility was the direct care staff observed to encourage the client's to buckle their seatbelts. Interview with the QMRP on the same day at approximately 1:00 PM revealed that the agency had the following safety policy: "When transporting clients in the agency vehicle each client is to wear a seatbelt for their safety en route to and from each destination". According to the Program Coordinator, the direct care staff were trained on the importance of buckling each client's seatbelts before departure;, however their was no evidence that training on the safety policy had occurred.	W 104	2. Staff were retrained on transportation policy and procedure including the use of seat belts on 08/15/08. The QMRP transportation co-ordinator and other administrative staff will continue to monitor the seat belt usage and other safety measures discussed in the transportation policy daily for one month, then monthly and periodically. Attachment "A"	08/15/08
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure that outside services met the needs of Client #2 in the sample. The finding includes: The facility failed to consistently monitor Client	W 120	QMRP monitored and held meeting with client #2's Day Program to discuss adaptive feeding equipment on 08/15/08. Please see sign in sheet. Attachment- A1- A4	08/15/08

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W 120	Continued From page 2 #2's adaptive feeding equipment being used at his day program. [See W159]	W 120		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's feeding supports for one of three clients in the sample. (Client #2) The finding includes: The QMRP failed to ensure that Client #2' day program used the prescribed adaptive feeding equipment as evidenced below: Observations of at lunch at the day program on August 11, 2008 at approximately 12:35 PM revealed Client #2 's plate was placed on top of a plate riser. The client, however, was not observed to use a riser at his residence during mealtimes (dinner, snacks and breakfast) on August 11th and August 12th. He was observed with his upper body bent over with his head was position over his plate. Interview with the day program staff revealed that the plate riser was used to keep Client #2's "head more upright while feeding". The observation at the day program confirmed the staff's comment.	W 159	The speech therapist reevaluated client #2 on 08/25/08 for feeding protocol. Recommendations include use of plate riser built up spoon, and fork during meals. The QMRP will ensure implementation of this program at home and Day Program. All staff members were trained on #2's feeding program on 08/25/08 (Please see attachment) 'A" A1 to A4	08/25/08

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W 159	Continued From page 3 Interview with the Qualified Mental Retardation Professional (QMRP) on August 12, 2008 at approximately 1:50 PM indicated that she was unaware of the day program's use of a plate riser. She further indicated that during her last monitoring visit to the day program in May 2008 she did not observe the client using a plate riser during meals. She stated that she was unaware that the day program was unaware that a plate riser was a requirement and being used at the day program. Client #2's Occupational Therapy (OT) assessment, dated January 4, 2007, was reviewed on August 12, 2008. Although the assessment recommended several adaptive feeding supports, it did not include the use of a plate riser.	W 159	#2's will be evaluated by O.T. to include the use of plate riser by 09/15/08. It should be noted that #2's is already using a plate riser.	09/15/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. There was no evidence that the facility provide direct care staff with training on policies and procedures for safe transporting of clients. [See	W 189	Please see answer W104.	

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W 189	Continued From page 4 W104] 2. The facility failed to ensure that the direct care staff ensured infection control practices. [See W454] 3. The facility failed to ensure that direct care staff used Client #6's gait belt during ambulation as evidenced below: Observation on August 11, 2008 at approximately 4:11 PM Client #6 entered the facility with a gait belt support around his waist. Staff were observed to hold the client hand, and not the gait belt, to stablize his gait which appeared unsteady. Client #6 was further observed to ambulate with out the use of staff assistance. Although the client continued to wear the gait belt, the staff did not use the gait belt to assist the client as he ambulate from the living room to the bathroom. The client was observed to leave the bathroom and navigate the stairs leading to the basement with no assistance from the staff. The client was observation on August 12, 2008 between 7:00 AM to 7:54 AM to ambulate through-out the facility without his gait belt support. At 7:53 AM, the a direct care staff placed the gaitbelt support on Client #6 in preparation to leave for the day program. The staff then allowed Client #6 to ambulate down the rear stairs to the van without any assistance. Interview with the QMRP at 12:30 PM, revealed that Client #6 was to wear his gait belt support due to his unsteady gait as recommended by the Physical Therapist (PT). Further interview with the QMRP revealed that the direct care staff had been trained by the PT on the proper use of the	W 189 2. 3.	Please see the answer to W 454 Staff were retrained on proper use of gait belt during ambulation on 08/15/08. The QMRP and HM will ensure that staff members implement the program consistently. Attachment "B" "C"	08/15/08

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W 189	Continued From page 5 gait belt support for Client #6 on April 24, 2008. Review of the PT assessment dated 3/27/08 included the following: "Client #6 is to use the gait belt during the day, so that the staff may assist him with ambulation. He should be assisted by a staff member for all ambulation and when negotiating the stairs" Review of the Human Rights Committee Minutes (HRC) date 8/5/08 revealed that the committee approved the client's use of the gaitbelt for ambulation at that time.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in the implementation of Client #3's Behavior Support Plan (BSP). The finding includes: The facility's direct care staff failed to implement Client #3's BSP as evidenced below: On August 12, 2008 at approximately 7:35 AM, Client #3 was observed walking around in the kitchen. Client #3 picked up and unwrapped a sandwich that was left on the kitchen counter. Once opened, he was observed to stuff half of the sandwich in his mouth. The House Manager responded "No! That belongs to someone else."	W 193	Staff members were trained on client #3's BSP targeted behaviors and ABC"s of data collection on 08/18/08. The QMRP emphasized the importance of continued monitoring, implementation and documentation of individuals behaviors in the training. QMRP and HM will review data daily. Psychologist will review data weekly. (Please see attached training sign in sheet). Attachment "D" to D2	8-18-08

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W 193	Continued From page 6 The house removed the remaining uneaten portion of the sandwich from the counter and threw it in the garbage. Later that morning, at approximately 7:43 AM, Client #3 was observed in the dining room at breakfast. He snatched a portion of Client #1's muffin from his plate while he was eating his breakfast. Client #1, in a loud and angry tone asked him to "Leave my food alone". Client #3 was then observed to eat some scramble eggs off the floor which had fallen from Client #6's plate who had eaten earlier. Staff responded by escorting Client #3 from the dining room area to the main level of the facility. The house manager instructed the direct care staff to document each episode of food snatching onto Client #3's his ABC data sheet. Interview with the house manager revealed that Client #3 had a target behavior of food snatching. Reportedly, a behavior support plan was in place to address this concern. Review of the Behavior Support Plan (BSP), dated August 10, 2008 revealed the following interventions to address food snatching behaviors: When Client #3 reaches for or picks up food which does not belong to him say "[Client #3] Stop!" If food drops, don't let [Client #3] aim for the food. The area should be clean immediately. Document all occurrences of food stealing on the behavior data collection sheet in [Client#3's] IPP book.	W 193	Please see W193 P.6	

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W 193	Continued From page 7 Review of the ABC data sheet failed to evidence that the direct care staff had documented the food snatching episodes in the program book as directed by the house manager.	W 193		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a current comprehensive occupational assessment on file that depicted their current functional status in that domain, for one of the three clients in the sample. (Client #2) The finding includes: [Cross Refer to W159] The facility failed to ensure that Client #2's occupational assessment had examined the need for a plate riser.	W 214	Please see the answer to W159.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients were provided the opportunities for making choices as part of their self-management. (Client #1 and #3) The findings includes:	W 247		

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W 247	Continued From page 8	W 247		
	1. On August 11, 2008 at 11:08 AM at the day program, Client #3 was observed to eat fruit cocktail from a Styrofoam bowl and drank water from a Styrofoam cup. At approximately 11:11 AM the day program staff were observed to throw Client #3's Styrofoam bowl and cup into the trash can. At 11:19 AM, Client #3 was observed to carry his lunch tray from the serving area to his seat with verbal prompts. At 11:26 AM, Client #3 was further observed to dumped his entire tray into the trash can. Interview with the day program's Lead Counselor (LC) 11:24 AM revealed that Client #3 had the ability to take his entire tray to the trash can daily. At no time did the day program staff allow Client #3 at each opportunity to throw his garbage.	1.	Day program was visited on 08/25/08 to discuss the need to encourage client #3 to allow to empty his tray after each meal as part of self management training. QMRP will visit day program on a quarterly or as needed basis to monitor the above. Attachment "E"	08/25/08
	2. On August 11, 2008 at approximately 4:52 PM, Client #1 was observed to get a package of chicken from the refrigerator and placed it into the sink independently. At approximately 4:53 PM, Client #1 was observed to set the entire table for six individuals with minimal verbal prompting. At 6:19 PM, direct care staff was observed to prepare each clients' dinner plate and placed it on the dining table. Interview with the direct care staff on the same day at approximately 6:40 PM revealed that Client #1 assist staffs in the kitchen during dinner almost daily. Further interview with staff revealed that Client #1 was capable of serving his own plate of food with supervision. Interview with the Qualified Mental Retardation Professional (QMRP) on August 12, 2008 at approximately 11:00 AM revealed that Client #1 has the ability to prepare his plate. Further interview with the	2.	Staff was trained on 08/15/08 to encourage client #1 to participate in meal preparation and serving his portion according to calorie need as per PMD's order. Staff to supervise the above and also assist client #1 to carry his plate to dining table as needed. Please see attachment. "B"	08/15/08

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W 247	Continued From page 9 QMRF revealed that Client #1 has tremors and would need assistance taking the plate to the table to reduce spillage. At no time did the direct care staff allow Client #1 to prepare his own food during dinner time.	W 247		
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 staff interview and record review the facility failed to ensure the implementation of an effective system of documenting clients' program progress/regression for one of three clients in the sample. [Clients #3] The finding includes: [Cross Refer W193] The facility failed to ensure that staff documented client #3's food snatching behaviors as required by his Individual Program Plan.	W 252	Please see answer to W193	
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by:	W 255		

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W 255	Continued From page 10 Based on observation, staff interview and record review, the QMRP failed to revise clients' objectives for one of three clients in the sample. [Client #1] The finding includes: On August 12, 2008 at approximately 1:00 PM, interview with the QMRP and review of the medication administration records revealed that Client #1 had a self-medication program that detailed the following task: 1. Pick up medication cup; 2. Take medication; 3. Pick up water; 4. Drink water; and 5. Trash cup. Interview with the Licensed Practical Nurse (LPN) on August 12, 2008 at 10:56 AM revealed that Client #2 "maybe able to punch out his medication". Further interview with the LPN revealed that the nursing staff had not provided Client #2 the opportunity to punch his medications to determine his functional abilities. Interview with the QMRP on the same day at approximately 11:30 AM revealed that "[Client #1] has a greater functioning ability and may possibly participate at higher level within his self-medication program. According to the QMRP the nurse is the responsible for the self-medication assessment for the facility. Review of the medical record revealed a self-medication assessment date July 2006. A review of this assessment in the physical assistance section indicated that the client could	W 255	Client #1's self medication assessment was reviewed and revised on 08/25/08. The new goal will start on 09/01/08. Please see attachment. "F1 - F5" Nursing staff received training on the implementation of self medication program, by the DON on 08/25/08. QMRP will ensure program is implemented by reviewing datasheets on monthly basis. Please see attachment. "G"	09/01/08 8-25-08

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W 255	Continued From page 11 participate by opening the medication container with verbal prompting. Further review of the records did not evidence a current self-medication assessment was available for review. According to the QMRP, it could not be determine by way of the assessment, the current functioning level of Client #1 in order to address the appropriateness of his current self medication objective.	W 255		
W 436	483.410(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 necessary adaptive equipment was furnished and maintained for one of the three clients included in the sample. (Client #2) The finding includes: [Cross Refer to W159] The facility failed to ensure that Client #2 was provided with the recommended adaptive feeding equipment as evidenced below: On August 11, 2008 at 12:35 PM, Client #2 was observed at his day program using a built up handle spoon and scoop dish to feed himself during his lunch. Further observations revealed that his plate was on a riser. Observations of the	W 436	Please see answer to W159	

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NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 47 QUINCY PLACE, 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 436	Continued From page 12 dinner meal on the same day at 6:40 PM revealed Client #2 used a regular table spoon for feeding and did not have a rise for his plate. The client was also observed during breakfast on August 12, 2008 at approximately 7:27 AM, using a regular table spoon and a three partition plate, which was not on a riser. Interview with the Qualified Mental Retardation Professional (QMRP) on August 12, 2008 at approximately 1:41 PM revealed that Client #2 had and was required to use a built up handled spoon for feeding. On August 12, 2008 at approximately 9:50 AM, review of the Occupational Therapist (OT) assessment dated January 4, 2007 revealed that Client #2 was prescribed a built up handled spoon, plate guard, bowl, and scoop dish for feeding. There was no evidence that these these items were made available during meals at the residence.	W 436		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, the facility failed to ensure that its direct care staff maintained a sanitary environment to avoid sources and potential transmission of infections. The findings includes: [Cross Refer to W193] The facility's direct care staff failed to ensure that spilled food was cleaned off the dining room floor to ensure a sanitary	W 454	Staff were retrained on infection control policy on 08/15/08 including cleaning the environment spillage after food immediately as it occurs on 08/15/08. QMRP and house manager will ensure that staff follow proper sanitory procedures. Attachment "H"	8/15/08

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

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NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

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W 454	Continued From page 13 environment in accordance with Client #3's Behavior Support Plan. Observation on August 12, 2008 at approximately 7:45 AM, Client #3 was observed to eat scramble eggs off the floor.	W 454		

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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW WASHINGTON, DC 20001		

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 11, 2008 through August 12, 2008. A random sample of three clients were selected from a population of six males with various disabilities. The findings of this survey were based on observations at the group home, three day programs, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window. The finding includes: An environmental walk-through was completed on August 11, 2008 which included the following: 1. No curtain or blinds were at Client #'s bedroom window. 2. Window blinds in the living room were bent and ripped. 3. Window blinds in the Client #2 and #6's bedroom were bent and ripped.	I 022	All repairs were completed during the survey on 08/11/08.	8-11-08

Health Regulation Administration

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

TITLE President

(X6) DATE 9/2/08

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I 074	Continued From page 1	I 074		
I 074	3503.3(c) BEDROOMS AND BATHROOMS	I 074		
	Each bedroom shall be equipped with at least the following items for each resident:			
	(c) Drawer space; and...			
	This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to provide adequate drawer space for each resident.			
	The finding includes:		The drawer was repaired on 08/11/08 during the survey QMRP and HM will continue to monitor the facility on an ongoing basis and take corrective measure to keep facility intact.	08/11/08
	An environmental inspection on August 11, 2008 revealed that Resident #5 dresser had a broken drawer.			
I 082	3503.10 BEDROOMS AND BATHROOMS	I 082		
	Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.			
	This Statute is not met as evidenced by: Based on observations and interview, the GHMRP failed to properly equip each bathroom with the appropriate items to meet each resident's need.			
	The finding includes:			
	An environmental walk-through was conducted on August 11, 2008. It was discovered that bathroom #3 did not have cups in the cup dispenser. According to interview with the QMRP and house manager, one of the client's had a behavior of stuffing cups in the toilet. Reportedly,		Cups were placed in a closed cabinet next to the bathroom accessible to individuals and staff on 08/11/08 QMRP and HM will continue to monitor the above.	08/11/08

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I 082	Continued From page 2 on several occasions the toilet had to be unclogged by a plumber.	I 082		
I 090	3504.1 HOUSEKEEPING 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. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Internal 1. The faucet in bathroom #3 made a loud noise and spurted water intermittently when turned on. 2. The bath tube in bathroom #3 was stained a dark substances and was discolored overall. 3. The third floor exit door hinges were loose and was difficult to close securely when opened. 4. The basement security door made a loud noise when being opened. 5. The closet in the dining room was without supported hinges on the right door.	I 090	Repairs were completed on 08/11/08 during the survey.	8-11-08

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I 095	Continued From page 3	I 095		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: Observations during the environmental walk-through on 8/11/08 approximately 1:40 PM, revealed a variety of caustic agents (bathroom cleaner toilet cleaner, glass cleaner, etc.) were being store in an unlocked cabinet located above the counter in the laundry areas. Additionally, large box of open detergent and a bottle of bleach were being stored on the floor unlocked.	I 095	DCHC, generally keep all cleaning materialsin a locked cabinet. This is definitely an oversight from this facility. All cleaning materials are now stored in a locked cabinet starting 08/11/08 QMRP will ensure that all chemicals are stored under lock and key on daily basis staff was in serviced on 08/15/08. QMRP and HM will continue to monitor the above on a consistent basis. Please see attachment 'H'	08/15/08
I 203	3508.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on 6/11/08 revealed that GHMRP failed to provide evidence of a current signed job descriptions for the newly promoted house manager and one direct care staff. (Staff #1)	I 203	House manager and staff #1 have signed job descriptions. Please see attachment. I⁴ - I⁴	

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I 206	3509.6 PERSONNEL POLICIES 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. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section. The findings include: Interview and review of the personnel records on August 12, 2008 revealed the GHMRP failed to have evidence of physical examination for two direct care staff. [Staff #1 and #2]	I 206	Health certificate of the two staff are attached. #1 & #2	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189	I 222		

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I 226	Continued From page 5	I 226		
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for one of two residents included in the sample. (Resident #3) The finding includes: See federal deficiency citation W454.	I 226	See response to W454 Pg. 13	
I 227	3510.5(d) 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 record review, the GHMRP failed to have on file for review current training in the agencies infection control practices for employees. The finding includes: See Federal Deficiency Report Citation W454	I 227		
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be	I 396		

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	HFD03-0028		08/12/2008
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I 396	Continued From page 6 necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure an Occupational Therapist had a current licenses on file. The finding includes: On August 12, 2008, interview with the Human Resource Manager revealed that the GHMRP did not have an OT at this time. According to the further interview the agency is in process of hiring a new OT. Review of the personnel records revealed that the GHMRP failed to have current license on file for an Occupational Therapist (OT).	I 396	A new O.T. has been appointed for DCHC. Please see attached current licence. K	8/15/08
I 401	3520.3 PROFESSION 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 GHMRP failed to ensure necessary adaptive equipment was furnished and maintained for one of the three residents included	I 401		

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I 401	Continued From page 7 in the sample. (Resident #2) The finding includes: The facility failed to ensure that Resident #2 was provided with the recommended adaptive feeding equipment. [See Federal deficiency report citation W436]	I 401	Please See response to W120 Pg. 2 Please See response to W436	