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

PRINTED: 06/13/2008
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
	09G009		05/23/2008

NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 414 "N" 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	W 000		
	This recertification survey was conducted from May 20, 2008 through May 23, 2008. The survey was initiated using the fundamental survey process; however, the survey was extended to examine the Condition of Active Treatment. The provider was advised of the extension on May 22, 2008 at approximately 11:00 a.m. Four clients were randomly selected from a client population of seven males with varying degrees of mental retardation.		Received 6/27/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	The survey findings of the survey was based on observation at the group home and day programs, interviews with staff at both locations and review of medical, habilitation and administrative records including incident reports.			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	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 observation, interview and record review the facility's Qualified Mental Retardation Professional (QMRP) failed to coordinate the care of the clients in the facility.			
	The findings include:			
	1. Based on observation, interview and record review the QMRP failed to ensure the day programs utilized recommended adaptive equipment for one of the four clients in the sample (Client #4)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mamta Tiwari | TITLE: Deputy Director D.C.H.C | (X6) DATE: 6/27/08

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 159	Continued From page 1	W 159		
	The finding includes: a. At the client's residence on May 21, 2008, during the snack observation at approximately 4:10 p.m., he ate cookies from a small plate that was placed on a plate elevator that had mesh looking material on top of it. Interview with the Qualified Mental Retardation Professional (QMRP) on May 23, 2008, at approximately 11:00 a.m. and verified by record review revealed that the plate elevator is a recommended piece of adaptive equipment and should have been utilized at the day program during meal time as prescribed.			
	b. During the review of Client #4 's record on May 20, 2008 at approximately 2:22 p.m., it documented that the client was required to have a dycem mat to stabalize his plate when eating. During the day program lunch observation on May 20, 2008 at 11:48 a.m. there was no dycem mat underneath his plate. Interview with the Qualified Mental Retardation Professional on May 23, 2008, at approximately11:00 a.m. and verified by record review revealed that thedycem mat was a recommended piece of adaptive equipment and should have been utilized at the day program as prescribed.	1- a&b	Plate elevator and a set of Dycem mat was supplied to the day program on 05/27/08 and the day program staff was trained by the QMRP on how to use the Dycem mat. The QMRP will make monthly visits to the day program to ensure that the protocol is being followed. See attachment A 1 – 6	5/27/08
	2. The QMRP failed to ensure staff are trained to ensure clients adaptive equipment is used at each meal. (See W189).	2.	Please see the answer to W189	
	3. The QMRP failed to ensure that clients were provided with assessments to determine their skill levels and subsequent needs. (See W214)	3.	IPP meeting are scheduled for Individuals to reassess individual's needs and to ensure that all objectives meet the individual's needs. Consultants will revise the program and will be amend if needed to accommodate the needs of Individuals.	06/6/08

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W 159	Continued From page 2 4. The QMRP failed to ensure that Client #3's fluid intake was monitored as ordered by the physician (See W322.7)	W 159	Please see the answer to W 322.7	
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 interview and record review, the facility failed to ensure staff are trained to ensure clients adaptive equipment is used at each meal for one of four clients in the sample (Client #4) The findings include:	W 189		
	The facility's staff failed to use Client #4 's Dycem mat appropriately as recommended by the interdisciplinary team as evidenced below: During the meal observations on May 21 and 22, 2008 at approximately 4:10 p.m. and 5:22 p.m. respectively revealed a green mat was placed on the table in front of Client #4. The plate elevator was placed on top of the mat. Interview with the QMRP on May 23, 2008 at approximately 1:30 p.m. and review of the clients record revealed that his Indavidual Support Plan (ISP) recommended that the client have a Dycem mat under his plate to stabalize it while he is eating and that the green mat observed unader the plate elevator was considered a Dycem mat. The staff acknowledged that the mat should have been placed on top of the plate elevator to stabalize the plate as recommened by the client's	W 189	QMRP/staff were trained on 06/02/08 on use of appropriate adaptive equipment for client #4. QMRP/HM will supervise the table setting before all meals. Please see attachment B 1 & 2	6/02/08

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W 189	Continued From page 3 ISP.	W 189		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility staff failed to ensure effective training to its staff to implement the individual program plan, for one of four clients (Client #3) included in the sample. The finding includes: On May 22, 2008 at approximately 5:22 p.m. Client #3 was observed with the Qualified Mental Retardation Professional (QMRP) using a learning device ("Read and Write Leap Frog"). The device would pronounce words in a story book when a wand was placed over words. The client was observed to placed the wand over words. Review of the client's record revealed an individual program plan (IPP) goal developed by the Speech pathologist to increase his receptive expressive language skills. According to the objectives, the client was to choose a story to use with the Leap Frog learning device and read along with the story. He was also to play the game associated with the story. It was noted that during the observation, the QMRP did not direct the client to read along with the story as directed in the IPP objective. Interview with the QMRP on May 23, 2008 at approximately 11:30 a.m.	W 194	An in service training was given by the speech pathologist on accurate implementation of client #3 IPP goal. QMRP will supervise proper implementation of the goal on weekly basis. An in-service training was done by the QMRP on 06/02/08 to ensure proper implementation of IPP goals. Please see attachment -C	6/02/08

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W 194	Continued From page 4 revealed the need for training on how to implement the program.	W 194		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for one of the three clients (Clients # 1 #2, #3) included in the sample. The finding includes: 1. The facility failed to ensure that Client #2 received an audiology assessment: Review of the medical record on May 21, 2008 at 10:33 a.m. revealed that Client #2 was evaluated by the Audiologist on July 5, 2002. At that time the client had normal middle ear function. Although the audiologist recommended that the client be evaluated annually; the primary care physician (PCP) indicated that she wanted the client to be evaluated in five years (2007). Review of the chart, however lacked evidence that the client was evaluated by the audiologist as recommended by the primary care physician (PCP).	W 322	1. Client #2 was seen by ENT on 06/26/08 for preparation of audiological evaluation. Audiology is scheduled for 07/08/08. QMRP will ensure that appointment is done as scheduled.	07/08/08
	2. The facility failed to ensure Client #2 received an ENT evaluation: Review of Client #2's medical record on May 23, 2008 at 11:20 a.m. revealed that an attempt by the ENT to evaluate the client was made on		2. It is very difficult to obtain appointment for routine exam. However an ENT appointment for client#2 was done on June 26,2008	6/26/08

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W 322	Continued From page 5 February 7, 2005. At that time the client was uncooperative, however, the ENT specialist recommended Debrox drops and that the client return sedated. Further review of the the medical record revealed that Client #2's PCP prescribed Debrox ear drops on the following dates July 1, 2007, February 6, 2008, and March 5, 2008. The PCP's notes revealed the following: July 9, 2007 - wax bilaterally, some removed (Debrox) will attempt to remove remaining wax. Audiology after wax removal. February 26, 2008 - positive for wax. Debrox for 2 weeks audiology after removal. March 5, 2008 - wax partially removee from the ears. Client uncooperative. Will schedule ENT for removal after premedication. Review of the record failed to show evidence that the client was evaluated by an ENT specialist. Interview with the Qualified Mental Retardation Professional on May 23, 2008 at 11:50 a.m. revealed that the client had a scheduled ENT appointment for November 3, 2008 (eight months after the PCP's recommendation). 3. The facility failed to ensure timely dental care for 2 of four clients in the sample. (See W356)	W 322		
		3.	Please see answer to W 356	
	4. The facility failed to ensure laboratory test ordered by the physician was obtained: Review of Client #3's medical record on May 21, 2008 at 2:54 p.m. revealed an order for the collection of a fasting blood sugar (FBS) and a	4.	Client #3 HgbA/A1C was done on 03/14/08.However the Lab was misfiled QMRP will make sure to keep all record in their assigned sections. See attachment -D	03/14/08

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W 322	Continued From page 6 hemaglobin A1c (HGB/A1C). The chart reflected that the FBS was collected, however did not reflect a HGB/A1C. The facility's nurse on May 22, 2008 at approximately 5:00 p.m. revealed that she would try to locate the aforementioned lab study, however, at the completion of the survey the laboratory report was not available for review.	W 322		
	5. The facility failed to ensure that Client #3's food intake was monitored as ordered by the physician: Review of Client #3's record on May 21, 2008 at approximately 3:15 p.m. revealed a physician's order to monitor the clients food intake at home and day program. The client was prescribed a 1500 kcal low cholesteral, low salt, high fiber with low calorie snacks and eight (8) glasses of water per day. Review of the client's nutritional assessment revealed his ideal body weight is between 174 lbs and 196lbs. Review of the clients weight documentation revealed that the client is approximately 62 lbs overweight. Interview with the QMRP revealed that there was no system in place to document how the monitoring of the clients food intake at the home and the day program as ordered by the PCP is conducted.	5 & 7	Client #3's food and fluid intake is being monitored since 06/02/08. All staff are properly trained. QMRP will check this on a routine basis. Monitoring tool is being shared with the day program. See Attachment – E 1-3	06/02/08
	6. The facility failed to ensure stool specimens were collected as ordered. Review of Client #3's medical record on May 22, 2008 at approximately 2:30 p.m. revealed a physician's order for a PSA, Hepatitis B profile and stool guiac (three specimens) to be collected. There was evidence in the record that the prostate-specific antigen (PSA) and a Hepatitis B profile; however, there was no evidence that the	6	Stool Guiac was done on June 15,16 and 17 and it was negative.	06/17/08

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W 322	Continued From page 7 stool specimens had been collected. Interview with the facility's nurse revealed that she was not sure if the specimens were collected as ordered. 7. The facility failed to ensure that Client #3's fluid intake was monitored as ordered by the physician. Review of Client #3's medical record revealed that he had a diagnosis of chronic renal disease. The physician's orders indicated to limit his fluid intake to 8 glasses per day. Interview with the QMRP on May 21, 2008 and the nurse on May 22, 2008 revealed that the facility has no system/procedure for monitoring the amount of fluid the client drinks per day at the home and at his day placement. 8. The facility failed to ensure Client #1 was evaluated for the use of a gait belt as ordered by the physician. During the survey Client #1 was observed with an unsteady gait and staff was observed assisting him by walking very close to him and holding his hands while he ambulated. Review of the clients records revealed a physician's order dated March 17, 2008, for the physical therapist (PT) to evaluate the client for the use of a gait belt for ambulation. Review of the Human right committee minutes dated May 13, 2008, revealed that the committee approved the use of the gait belt; however, the record failed to show evidence that the evaluation had occurred. Interview with the QMRP acknowledged that PT had not evaluated the client. At the time of the survey the client had not been evaluated for the use of a gait belt as recommended by the PCP.	W 322 7. 8.	Please see answer to W322 on page 7 On March 17, 2008 PMD requested PT evaluation for the use of Gait belt for client # 1 which was done on March 28, 2008 during the Client's Pre ISP (however it was not filed in the AMR) At that time the IDT discussed his ambulation abilities and the PT did not recommend a gait belt and the IDT agreed to the recommendation. However PT reevaluated him on 06/02/08 recommendation was that Client #1 does not need a Gait Belt @ this time and the PMD concurs with the PT. See attachment - F 1 & 2	06/02/08
W 356	483.460(g)(2) COMPREHENSIVE DENTAL	W 356		

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W 356	Continued From page 8 TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for three of the four clients included in the sample. (Clients #1, #2 and #3) The finding includes: 1. During the snack and dinner observations conducted on May 21, 2008 and May 22, 2008 respectively, Client #1 was observed receiving a chopped diet. Review of the client's medical record on May 22, 2008 at approximately 4:08 p.m. revealed that he was evaluated by a dentist on October 16, 2007. The dentist recommended that the client return to the office in six (6) months, however the chart failed to show evidence that the client was followed up in six months (April 2008) The lack of dental follow-up was discussed with the facility's nurse on May 22, 2008.	W 356 1.	Client #1 has a dental appointment on 07/1/08. The nursing staff and the QMRP will ensure that al appointments are executed in timely manner. See attachment - G	07/1/08
	2. Review of Client #3's medical record revealed that he was transported to the dental office on October 19, 2007. On that day it was documented that the client did not have an appointment that day but had one on November 19, 2007 The chart failed to show evidence that the client was evaluated by the dentist on November 19, 2007. The client was taken to the	2.	Client #3 dental appointment is scheduled for 7/10/08. The Nursing staff and the QMRP will ensure timely appointments. Please see Attachment - H	07/10/08

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W 356	Continued From page 9 dentist again on May 16, 2008. At that time it was documented as an annual dental exam with notation of plaque and supragingival calculus. The dentist recommended a full mouth scaling and prophylaxis treatment. The physician indicated that a pre-authorization request was to be sent to Medicaid and that the facility would called to re-schedule the appointment. On May 22, 2008 at 5:30 PM the nurse was asked if there was a dental appointment for the client. She indicated that there was no appointment at this time.	W 356		
	3. Review of Client #2's medical record on May 21, 2008 at 11:39 a.m. revealed that the client was evaluated by the dentist on May 30, 2007. The records indicated moderate calculus deposits and the client needed scaling. The records also indicated that the dentist would submit pre-authorization and a will call to reschedule. The next documented visit to the dentist was May 14, 2008 (12 months later). The note associated with the May 14, 2008 visit was identical to the note associated with the previous visit. The lack of dental services was brought to the attention of the of the Qualified Mental Retardation Professional on May 22, 2008.	3,	Client #2 dental appointment on 07/10/08.The Nursing staff and the QMRP will ensure timely appointments. Please see Attachment - I	07/10/08

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I 000	INITIAL COMMENTS This re-licensure survey was conducted from May 20, 2008 through May 23, 2008. Four clients were randomly selected from a client population of seven males with varying degrees of mental retardation. On May 22, 2008, questions surrounding the habilitation needs for one of the four clients arouse based on observations, interviews and records reviews. The survey findings of the survey was based on observation at the group home and day programs, interviews with staff at both locations and review of medical, habilitation and administrative records including incident reports.	I 000		
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 and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation and interview with the Facility Coordinator during the environmental inspection on May 23, 2008, revealed the following: The couch in the living room had cracks in the leather exposing the foam padding. Interview with the facility's maintenance coordinator revealed	I 090	Living room couch seats were replaced on 05/27/08. Please see attachment - J 1 & 2	05/27/08

Health Regulation Administration

Mamta Tiwari — Deputy Director | D.C.-H.C — 6/27/0

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 090	Continued From page 1 that the clients were moving from their current address and will have new furniture at their new location.	I 090		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The findings include: The GHMRP's staff failed to use Resident #4's Dycem mat appropriately as recommended by the interdisciplinary team as evidenced below: During the meal observations on May 21 and 22, 2008 at approximately 4:10 p.m. and 5:22 p.m. respectively revealed a green mat was placed on the table in front of Client #4. The plate elevator was placed on top of the mat. Interview with the QMRP on May 23, 2008 at approximately 1:30 p.m. and review of the clients record revealed that his Indavidual Support Plan (ISP) recommended that the client have a Dycem mat under his plate to stabalize it while he is eating and that the green mat observed unader the plate elevator was considered a Dycem mat. The staff acknowledged that the mat should have	I 229	The staff were retrained on 06/02/08 on appropriate use of adaptive equipment for client # 4. QMRP and the HM will supervise the table setting before all meals. Please see Attachment – B 1 & 2	06/02/08

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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) COMPLETE DATE
I 229	Continued From page 2 been placed on top of the plate elevator to stabalize the plate as recommened in the client's ISP.	I 229		