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

PRINTED: 05/29/2008
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
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 May 19, 2008, through May 21, 2008, using the fundamental survey process. A random sample of three clients was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews, and a review of records, including unusual incident reports.	W 000		
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, interview and record review, the facility failed to ensure that outside services met the needs of one of the three clients (Client #3) included in the sample. The findings include: The facility failed to ensure Client #3's day program staff was adequately trained to ensure his entire meal was served in accordance with his physician's orders. Observation of Client #3 at his day program on May 19, 2008 at 12:15 PM revealed the client was eating lunch. The client's meal that consisted of ham, bread, and carrot raisin salad, per staff interview, and was observed to be pureed and served in a high sided divided plate. During the observation, one staff person was observed to give the client a small cup of cut pineapples (not pureed). It should be noted that during the	W 120	The QMRP visited day program on 05/22/08 to observe and monitor his meal. Talked to case manager and staff attending to individual #3 who have assured that proper diet and texture in accordance with dietary order will be served and that they will continue to train the new staff as well. So the above mentioned problem does not occur again. QMRP and HM of DCHC will continue to visit day program on weekly basis initially then on monthly basis. Attachment - I	5/22/08

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 JUN 09 A 11:54

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gomey Stephen
TITLE: President
(X6) DATE: 6/9/08

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 120	Continued From page 1 observation the client's hand was unsteady and many pieces of the pineapple were observed to fall on the table. Additonally, the client was observed to refuse to eat all of the pineapple cup. Interview was conducted with the day program staff that was assisting Client #3 with his meal on May 19, 2008, at approximately 12:25 PM. According to the interview, the staff member was newly employed at the day program (less than one month). Review of Client #3's May 2008 Physician's Orders's on May 20, 2008, at 11:28 AM revealed the client had a prescribed diet order of an 1800 calorie, low cholesterol, high fiber, low fat pureed diet. At the time of the survey, the facility failed to ensure that the day program staff were provided with adequate training to make certain that Client #3's was provided his entire meal in accordance with his physician's order. Note: On May 22, 2008, (prior to the end of survey), the Qualified Mental Retardation Professional (QMRP) went to Client #3's day program to train staff on Client #3's prescribed diet. The QMRP further provided evidence of a mealtime observation that documented the client was provided with his lunch in accordance with his dietary orders.	W 120		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	W 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 137	Continued From page 2 failed to ensure the right of each client to retain the use of appropriately fitting shoes, for one of the three clients (Cliient #2) included in the sample. The findings include: Observation of Client #2 on May 19, 2008, at 8:11 AM revealed the client walking to the dining room. The client was wear a pair of black shoes that had a large gap (approximately 1 1/2 inches) between the client's heel and the back of the shoe. It should be noted that the client walked with a shuffle (feet remaining in contact with the ground). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on May 22, 2008 that revealed the client's feet tend to move to the front portion of the shoe, leaving a large gap in the rear of the shoe. At the time of the survey, it could not be determined that Client #2 was provided with appropriately fitting shoes.	W 137	The client #2 was taken to the shoe shop, foot measurement was taken and two pairs of shoes were purchased by making sure they fit him properly. The direct care staff was in serviced to ensure the right fitting shoes are used for client #2 at all times. Attachment #2	6/06/08
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure Client #2's individual program plan included an objective to address his dental needs. The finding includes:	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 227	Continued From page 3	W 227		
	The facility failed to ensure an objective to address Client #2's poor dental hygiene had been developed and/or implemented. (See W242)		Please see answer to W242.	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN	W 242		
	The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.			
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills, for two of the three clients (Clients #1and #2) included in the sample.			
	The finding includes:			
	1. The facility failed to ensure Client #2 received training to address his poor oral hygiene.	1.	An in service training was given to staff on 05/24/08 on proper tooth brushing and oral care. Encourage rinsing mouth after each meal and in between as needed. The QMRP and HM will continue to monitor the tooth brushing program. Data collection for oral hygiene program started effective 06/01/08. Attachment #3D – 3H.	6/01/08
	Review of Client #2's records on May 21, 2008 at 4:33 PM revealed the client's Nursing Assessment dated April 23, 2008. According to the assessment the client was noted to have "poor oral hygiene. Continued review of the client's records on May 21, 2008 at 4:30 PM revealed his IPP dated May 8, 2008. Review of the IPP failed to provide evidence of a training program to address the client's poor oral hygiene.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 242	Continued From page 4 2. The facility failed to ensure Client #1 was taught to wipe his mouth appropriately. Observation of Client #1 on May 19, 2008 at 4:45 PM revealed the client was observed to wipe his saliva on the cuff of his right shirt sleeve. At 5:50 PM, the client was again observed to wipe his saliva on the cuff of his sleeve. It should be noted that the client's shirt cuff was observed to be wet. Again at 6:31 PM, at 6:32 PM and at 6:35 PM the client was observed to wipe saliva on the cuff of his sleeve. Interview was conducted with a Qualified Mental Retardation Professional on May 21, 2008, that revealed the client wore a bib in the past to protect him from drooling. The QMRP further revealed that the drooling drastically decreased since the client had been receiving Dicyclomine HCL.(medication prescribed specifically to address the drooling) in 2005. At the time of the survey, however, the client failed to receive supports to address his behavior of wiping saliva on his shirt.	W 242 2.	The direct care staff was in serviced on 05/24/08 to encourage client #1 to use the napkin to wipe his saliva from his mouth. A box of napkin is to stay with him at all the times. Staff will coach him as needed. Attachment # 4	5/24/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. This STANDARD is not met as evidenced by: Based on observation, interview, and record	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 249	Continued From page 5 review, the facility failed to ensure each client received continuous active treatment services, including needed interventions, for one of the three clients (Client #3) included in the sample. The finding includes: The facility failed to ensure Client #3 was provided the opportunity to participate in his self medication program. (See W371)	W 249	Please see answer to W371.	
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 (Client 3) included in the sample. The finding includes: The facility failed to ensure an order for Client #3 to receive a psychiatric evaluation was followed. Review of Client #3's medical record on May 20, 2008 at 3:30 PM revealed a written order dated November 12, 2007, that documented the client was to receive an evaluation by the psychiatrist for aggressive behaviors. There was no evidence that Client #3 received the recommended psychiatric evaluation.	W 322	Client #3 has been a resident of DCHC since 1989. He does not exhibit aggressive behaviors. There were two isolated incidents of aggression in 2007 (related to staff changes). Also the covering QMRP was not familiar with client #3. She discussed this isolated episode with the PMD, who recommended psychiatric evaluation. Which was not warranted, based on psychologist's evaluation. The psychologist and PMD concurred on the above and the order was revoked as of 06/01/08. Please see attachment 5A and 5B. QMRP was given an in service on behavior management protocols etc. Attachment - 5 A & B & C	6/1/08
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client	W 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 362	Continued From page 6 at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record, the facility failed to ensure that the pharmacist reviewed drug regimens quarterly, for one of the three clients (Client #1) included in the sample. The finding includes: Review of Client #1's medical records on May 20, 2008 at 12:46 PM revealed a Pharmacy Review form. According to the form, the pharmacist conducted the last quarterly medication review for Client #1 on January 8, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on May 21, 2008 at 4:22 PM was conducted to ascertain information about the missing quarterly review. Further interview with the QMRP revealed the client's record was not in the facility at the time of the review conducted on on April 9, 2008 because Client #1 was on a medical appointment. At the time of the survey, the facility failed to ensure Client #1's drug regimen was reviewed quarterly.	W 362	Client #1 drug regimen was reviewed by the pharmacist on 06/06/08. QMRP will ensure that quarterly medication reviewed are completed on time in a timely manner. See attachment 6	06/06/08
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 371	Continued From page 7 taught to administer their own medications, for one of the three clients (Clients #3) included in the sample. The finding includes: Observation of the evening medication administration on May 19, 2008 at 6:10 PM revealed Client #3 was administered his medications by the residential Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from their bubble packs, pour his liquid medications into each medicine cup, and physically feed/administer the client each medication. It should be further noted that nurse was also observed to physically give the client his water to drink. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's Self Medication Assessment (dated October 22, 2007) on May 20, 2008 at 4:03 PM revealed the client had a formal self medication program that required the client to participate in his self medication regimen with 50% independence. Further review of the assessment revealed the client was required to pick up his medicine cup and pick up his water and drink it. At the time of the survey, the facility failed to ensure Client #3 was provided the opportunity to participate in his recommended self medication program.	W 371	The medication nurse has been retrained to implement and document self medication program for all including client #3. QMRP will continue to monitor the self medication program. See attachment #7	5/20/08
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	W 390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 390	Continued From page 8 failed to remove outdated drugs from use, for one of three clients (Client #1) in the sample. The finding includes: During the observation of the medication administration on May 19, 2008 at 6:23 PM, Client #1 was observed to receive Teargen eyedrops. After the medication administration, the facility's medication nurse handed the surveyor the box containing the eyedrops. Review of the medication label on Client #1's eyedrops revealed that an expiration date of May 8, 2008. Interview with the nurse on May 19, 2008 verified that Client #1's eyedrops had expired on May 8, 2008. The medication nurse indicated that he was not aware that the client's eyedrops had expired. Further interview with the medication nurse revealed that the charge nurse assigned to that facility was responsible for reviewing the medication cabinet. At the time survey, the facility failed to ensure that Client's #1's expired eye drops were removed from use.	W 390	An in service was done on 05/20/08 with medication nurse. The eye drops of client #1 was replaced immediately and the nursing staff will ensure that all medication that has expired will be removed from use. Please see attachment #7	05/20/08
W 436	483.470(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 that Client #1 was were provided with his	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 9 recommended/prescribed ted stockings. The finding includes: Observations on May 19, 2008, at 4:48 PM revealed Client #1 sitting in the facility's living room in a recliner chair with both of his legs elevated. The client was observed wearing mid calf white socks with the area above the socks exposed (bare skin seen). Review of the client's medical record on May 20, 2008 at 12:09 PM revealed a physician's order dated May 1, 2008. The order documented "ted hose to both feet - remove at bedtime." Interview with the Qualified Mental Retardation Professional (QMRP) on May 21, 2008 revealed that Client #1 had ted stockings that he usually wore under a his socks. At the time of the survey, however, the facility failed to ensure Client #1 was wearing his ted stocking as recommended.	W 436	The direct care staff was in serviced on the importance of the adaptive equipment especially emphasizing the need for client #1 to wear his Ted hose every day. As ordered by the PMD the QMRP and HM will make sure that this order is followed up by proper monitoring daily. Please See attachment 8 (8A - 8M)	05/24/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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
R 000	INITIAL COMMENTS A relicensure survey was conducted from May 19, 2008, through May 21, 2008. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	R 000		

Health Regulation Administration

Gymey Stephen

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

TITLE President

(X6) DATE 6/9/08

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 05/21/2008
NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE: 248 WALNUT STREET, NW WASHINGTON, DC 20011		

(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 000	INITIAL COMMENTS A relicensure survey was conducted from May 19, 2008, through May 21, 2008. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	I 000		
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 interview and record review, the GHMRP failed to ensure general and preventative care services, for one of the three residents (Resident #3) included in the sample. The findings include: The facility failed to ensure an interim order for Client #3 to receive a psychiatric evaluation was followed. Review of Client #3's medical record on May 20, 2008 at 3:30 PM revealed a written order dated November 12, 2007, that documented the client was to receive an evaluation by the psychiatrist for aggressive behaviors. Interview with the QMRP and continued review of Client #3's record on May 21, 2008, failed to provide evidence that	I 401	Client #3 has been a resident of DCHC since 1989. He does not exhibit aggressive behaviors. There were two isolated incidents of aggression in 2007 (related to staff changes). Also the covering QMRP was not familiar with client #3. She discussed this isolated episode with the PMD, who recommended psychiatric evaluation. Which was not warranted, based on psychologist's evaluation. The psychologist and PMD concurred on the above and the order was revoked as of 06/01/08. Please see attachment 5A and 5B. QMRP was given an in service on behavior management protocols etc. Attachment 5 A + B. C	6/1/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gymey Stephen

TITLE: President

(X6) DATE: 6/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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	Continued From page 1 Client #3 received the recommended psychiatric evaluation.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for three of the three residents (Residents #1, #2 and #3) included in the sample. The finding includes: I. The facility failed to ensure that outside services met each clients active treatment needs. The facility failed to ensure Client #3's day program staff was adequately trained to ensure his entire meal was served in accordance with his physician's orders. Observation of Client #3 at his day program on May 19, 2008 at 12:15 PM revealed the client was eating lunch. The client's meal that consisted of ham, bread, and carrot raisin salad, per staff interview, and was observed to be pureed and served in a high sided divided plate. During the observation, one staff person was observed to give the client a small cup of cut pineapples (not pureed). It should be noted that during the observation the client's hand was unsteady and many pieces of the pineapple were observed to fall on the table. Additionally, the	I 422	The QMRP visited day program on 05/22/08 to observe and monitor his meal. Talked to case manager and staff attending to individual #3 who have assured that proper diet and texture in accordance with dietary order will be served and that they will continue to train the new staff as well. So the above mentioned problem does not occur again. QMRP and HM of DCHC will continue to visit day program on weekly basis initially then on monthly basis. Attachment - I	5/22/08

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 05/21/2008
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20011		

(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 422	Continued From page 2 client was observed to refuse to eat all of the pineapple cup. Interview was conducted with the day program staff that was assisting Client #3 with his meal on May 19, 2008, at approximately 12:25 PM. According to the interview, the staff member was newly employed at the day program (less than one month). Review of Client #3's May 2008 Physician's Orders's on May 20, 2008, at 11:28 AM revealed the client had a prescribed diet order of an 1800 calorie, low cholesterol, high fiber, low fat pureed diet. At the time of the survey, the facility failed to ensure that the day program staff were provided with adequate training to make certain that Client #3's was provided his entire meal in accordance with his physician's order. Note: On May 22, 2008, (prior to the end of survey), the Qualified Mental Retardation Professional (QMRP) went to Client #3's day program to train staff on Client #3's prescribed diet. The QMRP further provided evidence of a mealtime observation that documented the client was provided with his lunch in accordance with his dietary orders. (See Federal Deficiency Report Citation W120) II. The facility failed to ensure each client received continuous active treatment services, including needed interventions. Observation of the evening medication administration on May 19, 2008 at 6:10 PM revealed Client #3 was administered his medications by the residential Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from their bubble packs,	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 422	Continued From page 3 pour his liquid medications into each medicine cup, and physically feed/administer the client each medication. It should be further noted that nurse was also observed to physically give the client his water to drink. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's Self Medication Assessment (dated October 22, 2007) on May 20, 2008 at 4:03 PM revealed the client had a formal self medication program that required the client to participate in his self medication regimen with 50% independence. Further review of the assessment revealed the client was required to pick up his medicine cup and pick up his water and drink it. At the time of the survey, the facility failed to ensure Client #3 was provided the opportunity to participate in his recommended self medication program. (See Federal Deficiency Report Citations W249 and W371)	I 422	The medication nurse has been retrained to implement and document self medication program for all including client #3. QMRP will continue to monitor the self medication program. See attachment #7 Please see answer to W249 + W371	5-20-08
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills, for two of the three clients (Clients #1and #2) included in the sample.	I 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G163		05/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

(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 432	Continued From page 4 The finding includes: 1. The facility failed to ensure Client #2 received training to address his poor oral hygiene. Review of Client #2's records on May 21, 2008 at 4:33 PM revealed the client's Nursing Assessment dated April 23, 2008. According to the assessment the client was noted to have "poor oral hygiene. Continued review of the client's records on May 21, 2008 at 4:30 PM revealed his IPP dated May 8, 2008. Review of the IPP failed to provide evidence of a training program to address the client's poor oral hygiene.	I 432	1. An in service training was given to staff on 05/24/08 on proper tooth brushing and oral care. Encourage rinsing mouth after each meal and in between as needed. The QMRP and HM will continue to monitor the tooth brushing program. Data collection for oral hygiene program started effective 06/01/08. Attachment #3 0-3H	6/01/08
	2. The facility failed to ensure Client #1 was taught to wipe his mouth appropriately. Observation of Client #1 on May 19, 2008 at 4:45 PM revealed the client was observed to wipe his saliva on the cuff of his right shirt sleeve. At 5:50 PM, the client was again observed to wipe his saliva on the cuff of his sleeve. It should be noted that the client's shirt cuff was observed to be wet. Again at 6:31 PM, at 6:32 PM and at 6:35 PM the client was observed to wipe saliva on the cuff of his sleeve. Interview was conducted with a Qualified Mental Retardation Professional on May 21, 2008, that revealed the client wore a bib in the past to protect him from drooling. The QMRP further revealed that the drooling drastically decreased since the client had been receiving Dicyclomine HCL.(medication prescribed specifically to address the drooling) in 2005. At the time of the survey, however, the client failed to receive supports to address his behavior of wiping saliva on his shirt.	2.	The direct care staff was in serviced on 05/24/08 to encourage client #1 to use the napkin to wipe his saliva from his mouth. A box of napkin is to stay with him at all the times. Staff will coach him as needed. Attachment #4	5/24/08

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 05/21/2008
NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW WASHINGTON, DC 20011		

(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 432	Continued From page 5 [See also Federal Deficiency Report Citation W242]	I 432	Please see answer to W242.	
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to remove outdated drugs from use, for one of three clients (Client #1) in the sample. The finding includes: During the observation of the medication administration on May 19, 2008 at 6:23 PM, Client #1 was observed to receive Teargen eyedrops. After the medication administration, the facility's medication nurse handed the surveyor the box containing the eyedrops. Review of the medication label on Client #1's eyedrops revealed that an expiration date of May 8, 2008. Interview with the nurse on May 19, 2008 verified that Client #1's eyedrops had expired on May 8, 2008. The medication nurse indicated that he was not aware that the client's eyedrops had expired. Further interview with the medication nurse revealed that the charge nurse assigned to that facility was responsible for reviewing the medication cabinet. At the time survey, the facility failed to ensure that Client's #1's expired eye drops were removed from use.	I 484	An in service was done on 05/20/08 with medication nurse. The eye drops of client #1 was replaced immediately and the nursing staff will ensure that all medication that has expired will be removed from use. Please see attachment #7	05/20/08