STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G166	A. BUILDING _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	[redacted] WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 09/05/18 through 09/07/18. A sample of three clients were selected from a population of six males. This survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. HM - House Manager HRC - Human Rights Committee mg - milligram QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the specially constituted committee reviewed and approved sedation administered prior to appointments, for one (1) of six (6) clients residing in the facility (Client #1). Findings included:	W 262		

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

Marietta Tindal | V.P. D.C.H.C. | 10/4/18

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 262	Continued From page 1 During the entrance conference on 09/05/18 at 10:01 AM, the QIDP stated that Client #1 received radiation therapy five (5) days per week. At 2:10 PM, Client #1 was observed in the facility's living room, sleeping on the sofa. At 3:00 PM, Client #1 continued to sleep on the sofa. The HM said that the client was "probably still sedated" from radiation that morning. When asked if Client #1 received sedation for the appointment, the HM replied, "Every morning before he leaves, he gets sedation here." On 09/06/18, review of Client #1's medical record showed a consent from the client's guardian for radiation treatment and 2 mg of Ativan 90 minutes prior to radiation. The record also showed that the HRC had approved radiation treatment. The record, however, failed to show that the HRC had approved the use of sedation for the client's daily appointments for radiation treatment. At 3:03 PM, the QIDP stated that there was a meeting to discuss Client #1's radiation treatment. The sedation was not discussed in the meeting because it was assumed that the client would be able to tolerate the radiation. The QIDP further stated that Client #1 tolerated the first treatment, but "the next treatments could not be done without being medicated." The QIDP further said that he believed the guardian's consent for radiation treatment was sufficient as consent for sedation, since the HRC had already approved the radiation treatment. At the time of survey, the facility failed to ensure that a restrictive treatment was approved prior to implementation.	W 262	An in-service training was completed with QIDP on 09/08/18 by Program Manager regarding Policy & Procedure for sedation, restrictive treatment and approval. DCHC QIDP/QA will ensure that all approvals are obtained prior to procedures. All approvals will be discussed quarterly during HRC reviews. (Please see Attachment "A")	9/8/2018

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Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 09/05/18 to 09/07/18. A sample of three residents was selected from a population of six males. The findings of the survey were based on observations, interviews, and reviews of resident and administrative records. No deficiencies were cited.	I 000		

Health Regulation & Licensing Administration

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Mamta Tiwari | V.P/D.C.H.C | 10/4/18

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E 000	Initial Comments An emergency preparedness survey was conducted from 09/05/18 through 09/07/18. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. DSP - Direct Support Professional EPL - Emergency Preparedness Leader EPP -Emergency Preparedness Plan	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 1	E 037		

expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

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E 037	Continued From page 2	E 037		

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness

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E 037	Continued From page 3	E 037		

policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to document the provision of initial training in emergency preparedness policies and procedures to all new and existing staff, for six of six clients residing in the facility (Clients #1, 2, 3, 4, 5 and 6).

Findings included:

On 09/7/18 beginning at 9:30 AM, the facility's EPP was reviewed. Review of the provided

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E 037	Continued From page 4 in-service training signature sheets dated 11/28/17 and 11/29/17 which were entitled, "Emergency Preparedness Plan" showed no evidence that two staff (DSPs #7 and 8) who worked the weekend overnight shift (6:30 PM - 6:30 AM) received training. According to the facility's emergency preparedness policy, "All staff will be given comprehensive training on the overall scope of emergency planning and specific training on procedures and policies that are important to their assigned duties. Periodic training, drills and exercises will be conducted to maintain staff proficiency in the emergency plan and its implementing procedures." On 09/7/18 at 1:43 PM, the EPL stated that DSPs #7 and 8 should have received initial EPP training. The EPL was not able to provide evidence of the training. At the time of the survey, there was no evidence each staff working at the facility received initial training on the emergency preparedness plan, policies and procedures.	E 037	An in-service training was completed to all staff on 09/09/18 by Program Manager on Emergency Preparedness Policy and Procedures. DCHC PM/QA will conduct bi-annual training to ensure compliance with all staff. (Please see Attachment "B")	09/09/18