STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G227	A. BUILDING _____ B. WING _____	01/24/2019

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

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W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from 01/22/19 to 01/24/19. A sample of three clients was selected from a population of six men. The 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.

The following abbreviations will appear throughout the report:

DSP - Direct Support Professional
HM - House Manager
IPP - Individual Program Plan
LPN - Licensed Practical Nurse
MG - Milligrams
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse

W 189 STAFF TRAINING PROGRAM — W 189
CFR(s): 483.430(e)(1)

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 observations, interview and record review, the facility failed to ensure that each staff was trained effectively to (I) consistently implement each client's communication objective, and (II) ensure each client's coffee guidelines were consistently implemented for two of three

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mamta Singh	V.P./D.C-M.C	2/19/19

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 189	Continued From page 1 clients in the core sample (Client #2 and 3). Findings included: (I) On 01/22/19 at 7:02 AM, observations showed Client #3 sitting in the living room area in an upright position with his eyes closed while the television was on the news channel. The surveyor asked DSP #1 to introduce the clients'. DSP #1 asked Client #3 his name and the client mumbled a low sound (unclear). Client #3 appeared to be visually impaired. At 9:09 AM, the QIDP provided the surveyor with the clients' IPPs. Client #3 had a communication objective that stated, "With verbal and tactile cues and reminders, [client name] will touch a speech generating device to say the name, address, personal information and requested preferred activities with 80% compliance over 3 months." Further review revealed the following strategies/modalities: 1. Put the device in his hand. 2. Tell him to push the button. 3. Aid him if he does not find or push the button. Provide hand over hand assistance if needed. 4. Offer verbal praise when he pushes the button and repeats the message. 5. Repeat the message by saying it out loud. 6. Mark the data sheet. Store the device in a safe place. Train daily (Monday - Friday) Continued observations from 2:28 PM to 7:10 PM	W 189	1 An inservice training was done on 02/10/19 by Speech Pathologist of DCHC to QIDP, HM and all DSP's to follow the teaching strategies outlined in the communication program for client # 3. The QIDP will monitor the communication program implementatin by DSP with communication device once /week for one month and then routinely/as needed. (Please see Attachment "B1 & B2")	02/10/19

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W 189	Continued From page 2 showed Client #3's communication device was not used during this time period. At 5:52 PM, Client #3 was verbally instructed to turn on the keyboard. On 01/23/19 at 11:37 AM, interview with the HM confirmed that Client #3 had a communication device that was to be used daily during opportune times. (i.e. say his name, what activity he wants to engage in, say address, personal information, do you want to play the keyboard, etc.) When asked, the HM said all staff had been trained on the use of Client #3's communication device. On 01/24/19 at 12:04 PM, review of the facility's in-service training records revealed that on 12/10/18, DSP #1 and all staff had received training on Client #3's communication objective. However, observations on 01/22/19 revealed that the training was not effective. (II) On 01/22/19, at 6:35 AM, observations showed DSP #2 assisted Client #2 from the bathroom to the living room. After DSP #2 assisted Client #2 to the sofa, Client #2 asked for a cup of coffee. Client #2 then repeated his request for coffee. At 8:05 AM, Client #2 washed his hands then sat at the table for breakfast. Client #2's breakfast consisted of sausage, toast, oatmeal, juice and milk. Client #2 was not observed to receive his coffee. It should be noted that DSP #2's shift ended before breakfast was served. On 01/22/19 at 8:43 AM, interview with DSP #3, who set the table for breakfast, stated that Client #2 receives coffee at his day program. DSP #3 said that staff did not give Client #2 coffee every day.	W 189	II	An inservice training was conducted on 01/26/19 by Psychologist to QIDP, HM and all DSP's for client # 2, emphasising the coffee guidelines and to f ollow and to implement it. Also rediscussed the coffee protocol with day program and they are not to serve cofee to client # 2. (DCHC coffee protocol is already at Day Program). The QIDP / HM will monitor breakfast and dinner once a week for 1 month and then routinely as needed. (Please see attachment "A1, A2, A3 & A4")	01/26/19

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W 189	Continued From page 3	W 189		

On 01/23/19, at 9:38 AM, review of Client #2's "coffee guidelines" dated 09/25/18, revealed Client #2 can have one cup of decaffeinated coffee at breakfast and one cup at dinner. According to the guidelines, "no coffee should be given at the day program." Further review revealed that staff should offer Client #2 a choice of two beverages (i.e. herbal tea, lactose free warm milk, warm cocoa, ice tea, lemonade, fruit juices and water).

On 01/24/19, at 12:04 PM, review of the staff in-service training records showed that DSP #3 and all staff received training on Client #2's coffee guidelines on 12/10/18. However, observations on 01/22/19 revealed that training was not effective.

At the time of the survey, there was no evidence that training had been effective.

W 249 PROGRAM IMPLEMENTATION
CFR(s): 483.440(d)(1) — W 249

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 review, the facility staff failed to ensure each

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W 249	Continued From page 4 client's communication training program was implemented, for one of three clients in the core sample (Client #3). Findings included: On 01/22/19 at 7:02 AM, observations showed Client #3 sitting in the living room area in an upright position with his eyes closed while the television was on the news channel. The surveyor asked DSP #1 to introduce the clients'. DSP #1 asked Client #3 his name and the client mumbled a low sound (unclear). Client #3 appeared to be visually impaired. At 9:09 AM, the QIDP provided the surveyor with the clients' IPPs. Client #3 had a communication objective that stated, "With verbal and tactile cues and reminders, [client name] will touch a speech generating device to say the name, address, personal information and requested preferred activities with 80% compliance over 3 months." Further review revealed the following strategies/modalities: 1. Put the device in his hand. 2. Tell him to push the button. 3. Aid him if he does not find or push the button. Provide hand over hand assistance if needed. 4. Offer verbal praise when he pushes the button and repeats the message. 5. Repeat the message by saying it out loud. 6. Mark the data sheet. Store the device in a safe place. Train daily (Monday - Friday).	W 249	An inservice training was done on 02/10/19 by Speech Pathologist of DCHC to QIDP, HM and all DSP's to follow the teaching strategies outlined in the communication program for client # 3. The QIDP will monitor the communication program implementation by DSP with communication device onec/week for one month and then routinely/as needed. (Please see Attachment "B1 & B2")	02/10/19

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W 249	Continued From page 5 Continued observations from 2:28 PM to 7:10 PM showed Client #3's communication device was not used during this time period. At 5:52 PM, Client #3 was verbally instructed to turn on the keyboard. On 01/23/19 at 11:37 AM, interview with the HM confirmed that Client #3 had a communication device that was to be used daily during opportune times (i.e. say his name, what activity he wants to engage in, say address, personal information, do you want to play the keyboard, etc.). When asked, the HM said all staff had been trained on the use of Client #3's communication device. At 12:20 PM, the HM brought Client #3's communication device to the surveyor and demonstrated to the surveyor how the device was to be used. The HM stated that he would make sure the communication device is available for staff and Client #3 at all times. At the time of the survey, the facility failed to implement Client #3's communication objective, as recommended.	W 249	An in-service traing was done on 02/10/19 by Speech Pathologist of DCHC to QIDP, HM and all DSP's to follow the teaching strategies, outlined in the communication device for client # 3. The QIDP will monitor the communication program implementation by DSP with communication device once/ week for one month and then outinely/ as needed. The QIDP will monitor and ensure that the communication program is implemented daily and the communication device is available for the DSP to implement the program to client # 3. (Please see Attachment "B1 & B2")	02/10/19
W 388	DRUG LABELING CFR(s): 483.460(m)(1)(i) Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the pharmacist labeled each medication completely, for one of six clients residing in the facility that	W 388		

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W 388	Continued From page 6 received medications (Client #5). Findings included: On 01/22/19, at 8:12 AM, the LPN was observed administering Client #5's morning medications. During the verification process, it was discovered that the label on two blister packs of Divalproex capsules failed to include the dosage amount and frequency of medication administration. Further verification revealed that the label stated "use as directed". According to a physician's order dated 01/01/19, four 125 mg capsules (500mg) were to be administered by mouth three times daily for seizure. Interview with the RN on 01/24/19, at 10:18 AM, revealed that the facility was using a different pharmacy. The RN further stated that she telephoned the pharmacy and requested that they send the next order of Divalproex with a label complete with the prescribed dosage, frequency and route of administration. At the time of survey, the facility failed to ensure that all prescribed medications were labeled.	W 388	There was a meeting with Director of Pharmacy of New Hampshire Pharmacy on 01/25/19 regarding the citation. DCHC was assured that all medications from this day onward will be properly labelled as per POF (Physician Order Form). DCHC Nurse will monitor the above. (Please see Attachment "C")	01/25/19

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E 000	Initial Comments An emergency preparedness survey was conducted from 01/22/19 through 01/24/19. 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. EPP - Emergency Preparedness Plan PM - Program Manager	E 000		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of	E 039		

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

Mamta Gupai | V.P/D.C.H.C. | 2/19/19

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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E 039	Continued From page 1	E 039		

the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community based exercise with outside sources, for six of six clients residing in the facility (Clients #1, 2, 3, 4, 5 and 6).

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E 039	Continued From page 2 Findings included: On 01/24/19 at 1:07 PM, review of the facility's EPP dated November 2017 showed that the facility did not participate in a full-scale community based exercise to present. At 01/24/19 at 2:05 PM, the PM said during an interview that he had reached out to several outside sources (i.e. fire department, recreation centers and other group homes) about coordinating a full-scale exercise with the facility. When asked about the documents, the PM stated that he had documentation of attempts made to coordinate a full-scale exercise with outside sources. The documents were not provided to the surveyor by the time the survey ended.	E 039	DCHC completed a full scale exercise on 09/11/2018 with collaborationof all DCHC facilities in reference to Hurricane Florence. DCHC PM/QA will ensure that documentation is available for review in all respective facilities upon completion of drills. (Please see Attachement "E") DCHC is also in communication with DPR/DC to establish contact with recreation centers in DC to develop strategies for upcoming drills. (Please see Attachment "F") DCHC PM will ensure that full scale/Tabletop drills are completed as per the policy and available for reivew.	09/11/18 02/19/19

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I 000	INITIAL COMMENTS A licensure survey was conducted from 01/22/19 through 01/24/19. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and reviews of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities HM - House Manager IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional	I 000		
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 GHIID staff failed to ensure each resident's communication training program was implemented, for one of three residents in the core sample (Resident #3). Findings included: On 01/22/19 at 7:02 AM, observations showed Resident #3 sitting in the living room area in an upright position with his eyes closed while the television was on the news channel. The	I 422	An inservice training was done on 02/10/19 by Speech Pathologist of DCHC to QIDP, HM and all DSP's to follow the teaching strategies outlined in the communication program for client # 3. The QIDP will monitor the communication program implementatin by DSP with communication device once /week for one month and then routinely/as needed. (Please see Attachment "B")	02/10/19

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I 422	Continued From page 1	I 422		

surveyor asked DSP #1 to introduce the residents'. DSP #1 asked Resident #3 his name and the resident mumbled a low sound (unclear). Resident #3 appeared to be visually impaired.

At 9:09 AM, the QIDP provided the surveyor with the residents' IPPs. Resident #3 had a communication objective that stated, "With verbal and tactile cues and reminders, [resident name] will touch a speech generating device to say the name, address, personal information and requested preferred activities with 80% compliance over 3 months." Further review revealed the following strategies/modalities:

1. Put the device in his hand.

2. Tell him to push the button.

3. Aid him if he does not find or push the button. Provide hand over hand assistance if needed.

4. Offer verbal praise when he pushes the button and repeats the message.

5. Repeat the message by saying it out loud.

6. Mark the data sheet. Store the device in a safe place. Train daily (Monday - Friday)

Continued observations from 2:28 PM to 7:10 PM showed Resident #3's communication device was not used during this time period. At 5:52 PM, Resident #3 was verbally instructed to turn on the keyboard.

On 01/23/19 at 11:37 AM, interview with the HM confirmed that Resident #3 had a communication device that was to be used daily during opportune times (i.e. say his name, what activity he wants to

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I 422	Continued From page 2 engage in, say address, personal information, do you want to play the keyboard, etc.). When asked, the HM said all staff had been trained on the use of Resident #3's communication device. At 12:20 PM, the HM brought Resident #3's communication device to the surveyor and demonstrated to the surveyor how the device was to be used. The HM stated that he would make sure the communication device is available for staff and Resident #3 at all times. At the time of the survey, the GHIID failed to implement Resident #3's communication objective, as recommended.	I 422		