STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G254	A. BUILDING _____ B. WING _____	02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DC HEALTH CARE, INC	[redacted] 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 02/06/19 to 02/08/19. A sample of three clients was selected from a population of thee males and two females. 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: ASAP - As Soon As Possible IPP - Individual Program Plan LPN - Licensed Practical Nurse RN - Registered Nurse	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 failed to ensure that each client's self-medication training program was implemented when the opportunity was presented, for one of three clients in the sample	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: PROGRAM MANAGER | (X6) DATE: 3/8/19

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 249	Continued From page 1 (Client #2). Findings included: On 02/06/19 at 5:07 PM, observations of the evening medication pass showed that the LPN punched one medication into a medication cup and handed the medication cup to Client #2. Client #2 then consumed the medication, picked up his water and drank the water. At 5:30 PM, the LPN said during an interview that she did not think any of the clients' had a self-medication program. The LPN then stated, "You have to ask the RN". It should be noted that the RN was in the facility at the time the medication pass occurred. On 02/07/19 at 1:22 PM, review of Client #2's IPPs revealed with 50% verbal reminders and supervision by licensed staff, [client name] will participate in his self-medication. Further review of the IPP revealed the following strategies: 1. Pick up the medicine. 2. Obtain the key to the medication box. 3. Identify the AM or PM card as needed. 4. Pop the medication pills from the package into a medication cup. 5. Take the medication. 6. Drink the water. 7. Lock the medication box. 8. Secure the key. 9. Secure the medication box. 10. Put the cup in the trash can. On 02/08/19 at 12:32 PM, a telephone interview was conducted with the facility's RN. The RN said that Client #2 had a self-medication program	W 249	The medication nurses were retrained by the RN on 02/11/19. The RN and QIDP will monitor the self-medication program for all people daily for two weeks and monthly for three months. (Please see Attachment "A1, A2")	02/11/19

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W 249	Continued From page 2 that should be implemented during the AM and PM medication pass. The RN stated that she did not see the evening LPN implement Client #2's self-medication on 02/06/19. The RN further stated that she would provide in-service training to all LPNs on the implementation of Client #2's self-medication ASAP. At the time of the survey, the facility failed to implement Client #2's self-medication administration program, as recommended.	W 249		

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	HFD03-0286	A. BUILDING: _____ B. WING _____	02/08/2019

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I 000	INITIAL COMMENTS A licensure survey was conducted from 02/06/19 through 02/08/19. A sample of three residents was selected from a population of three males and two females 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. ASAP - As Soon As Possible GHIID - Group Home for Individuals with Intellectual Disabilities IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	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 failed to ensure that each resident's self-medication training program was implemented when the opportunity was presented, for one of three residents in the sample (Resident #2). Findings included: On 02/06/19 at 5:07 PM, observations of the evening medication pass showed that the LPN	I 422		

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I 422	Continued From page 1 punched one medication into a medication cup and handed the medication cup to Resident #2. Resident #2 then consumed the medication, picked up his water and drank the water. At 5:30 PM, the LPN said during an interview that she did not think any of the residents' had a self-medication program. The LPN then stated, "You have to ask the RN". It should be noted that the RN was in the GHIID at the time the medication pass occurred. On 02/07/19 at 1:22 PM, review of Resident #2's IPPs revealed with 50% verbal reminders and supervision by a licensed staff, [resident name] will participate in his self-medication. Further review of the IPP revealed the following strategies: 1. Pick up the medicine. 2. Obtain the key to the medication box. 3. Identify the AM or PM card as needed. 4. Pop the medication pills from the package into a medication cup. 5. Take the medication. 6. Drink the water. 7. Lock the medication box. 8. Secure the key. 9. Secure the medication box. 10. Put the cup in the trash can. On 02/08/19 at 12:32 PM, a telephone interview was conducted with the GHIID's RN. The RN said that Resident #2 had a self-medication program that should be implemented during the AM and PM medication pass. The RN stated that she did not see the evening LPN implement Resident #2's self-medication on 02/06/19. The RN further stated that she would provide an in-service training to all LPNs on the	I 422	The medication nurses were retrained by the RN on 02/11/19. The RN and QIDP will monitor the self-medication program for all people daily for two weeks and monthly for three months. Please see Attachment "A1, A2"	02/11/19

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I 422	Continued From page 2 implementation of Resident #2's self-medication ASAP. At the time of the survey, the GHIID failed to implement Resident #2's self-medication administration program, as recommended.	I 422		

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E 000	Initial Comments An emergency preparedness survey was conducted from 02/06/19 through 02/08/19. 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. DSP - Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Plan HM - House Manager PM - Program Manager QIDP - Qualified Intellectual Disabilities Professional	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:	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: PROGRAM MANAGER | (X6) DATE: 3/8/19

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E 037	Continued From page 1 (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 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.	E 037		

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E 037	Continued From page 2 (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[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.	E 037		

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E 037	Continued From page 3	E 037		

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness 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 ensure each staff demonstrated knowledge of the emergency procedures (specifically describing and/or demonstrating the tracking system used to document locations of clients and staff during an emergency event), for two of eight staff (DSP #4 and 8).

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E 037	Continued From page 4 Findings included: On 02/07/19 at 6:27 AM, DSP #4 said during an interview that she received training on the facility's tracking system used to track clients and staff during an emergency event. When asked to describe the tracking system, DSP #4 stated she would take a head count when they evacuated to the meeting point at Kansas Avenue and Tuckerman Street during a fire drill. DSP #4 further stated that she was not aware of any specific form to document the locations of clients during an emergency. At 1:29 PM, interview conducted with DSP #8 revealed that she has had training on the facility's emergency procedures, which included tracking the locations of clients and staff during an emergency. When asked to describe the tracking system, DSP #5 stated she would take a head count when they evacuated to the meeting point at Kansas Avenue and Tuckerman Street. DSP #5 further stated that she was not sure if there was a form used to document the location of clients and staff should they have to evacuate to another locations. On 02/08/19 beginning at 1:01 PM, review of the EP last dated 06/14/18 revealed a policy and procedure entitled, "Client and Staff Tracking". According to the policy, the QIDP and HM will maintain daily a attendance log and schedule to identify the whereabouts of clients and staff at all times during an evacuation. Continued review of the policy revealed [agency name] will utilize transportation log, staff schedules and emergency log to keep track of all the clients and staff during and after an emergency.	E 037	Staff was retrained on 02/12/19 on the emergency procedure and the tracking on the location of both residents and staff. QIDP will ensure that staff is knowledgeable on the tracking system by weekly discussion and testing for 2 weeks and the monthly for 3 months. (Please see Attachment "B1, B2, B3") DCHC completed a full scale exercise on 02/12/19 with collaboration of 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 Attachment "C") DCHC is also in communication with DPR/DC to establish contact with recreation centers in DC to develop strategies for upcoming drill. (Please see Attachment "D") DCHC PM will ensure that full scale/Tabletop drills are completed as per the policy and available for review.	02/12/19 02/12/19

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E 037	Continued From page 5 At the time of the survey, the facility failed to ensure all staff demonstrated knowledge of the emergency procedures.	E 037		
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 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	E 039		

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E 039	Continued From page 6	E 039		

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 five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5).

Findings included:

On 02/08/19 at 1:53 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.

On 01/24/19 at approximately 2:50 PM, the PM

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E 039	Continued From page 7 said during an interview that he had reached out to several outside sources 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. No additional information was provided for review before the survey ended on 2/8/19.	E 039		