STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G226	A. BUILDING _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DC HEALTH CARE	6508 EASTERN AVE NE 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 at this facility from December 03, 2025, through December 05, 2025. A sample of three clients was selected from a census of five. The survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and record reviews.	W 000		
W 189	STAFF TRAINING PROGRAM 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, interviews and record reviews, the facility failed to ensure continuous and ongoing training for offering of liquids during meals in accordance with the eating protocol, for one of the three clients in the sample (Client #1). Findings included: A review of Client #1's Eating Protocol dated 03/07/2025 developed by the Speech Language Pathologist (SLP) revealed that the client has a history of mild oral dysphagia. Per the protocol the eating protocol, the client tends to eat without fully clearing his mouth and over fills his mouth. The protocol recommended that the staff should attempt to have the resident alternate liquids and solids, while eating, and after 2-3 bites of food, encourage the client to take a drink with gesture/verbal cue to his cup.	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Nalin Mishra, Program Director	02/09/2026

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W 189	Continued From page 1 Observation during lunch on 12/03/2025 beginning at 12:30 PM, showed that Client #1 was spoon-fed all the solid food first by DSP #17, and then offered a punch which he drank 100%. Further observation during breakfast on 12/05/2025, at 7:50 AM, showed that DSP #17 spoon-fed Client #1 all the solid food before offering liquids to drink. The client drank several sips of milk then refused to drink and then drank 4 ounces of water. At 7:58 AM, a review of the facility's training records dated 03/07/2025 revealed that staff had received training on Client #1's Eating Protocol. Further review of the facility's staff schedule revealed that Direct Support Professional (DSP) #17 began working with Client #1 on 11/17/2025. During an interview at 8:03 AM, DSP #17 confirmed that he had been working with Client#1 for about three weeks and was trained on the client's eating protocol. According to the DSP, when Client #1 is offered liquids while being fed solid food, the client usually refuses them. The Qualified Intellectual Disabilities (QIDP) during an interview on 12/05/2025 at 3:18 PM confirmed that all staff were trained on Client #1's eating protocol dated 03/05/2025, and that DSP #17 who was a new staff member since 11/12/2025, received the training during orientation.	W 189	On 12/24/25, the DCHC Speech & Language Pathologist retrained all staff on Mr. Jamison's eating protocol. The HM & QIDP will monitor the program daily for one month and will continue on going staff training as needed. Please see Attachment "B1"	12/24/25
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program	W 251		

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W 251	Continued From page 2 plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that staff implemented the client's individual program plan (IPP), specifically 1:1 supervision and use of gait belt during ambulation as written for one of the three clients in the sample (Client #5). Findings included: The review of Client #5's IPP dated10/03/2025 revealed an objective that indicates that the client requires one-to-one supervision to ensure safety during ambulation in the house and outdoors in the community. Per the plan requires the client to wear a gait belt for all transfers and ambulation so that staff can assist if he loses his balance. The plan also instructed staff to stand next to the client during ambulation without holding the gait belt continuously, to prevent the client from pulling forward. Observations on 12/03/2025 from 6:40 AM to 8:13 AM showed Client #5 ambulating without a gait belt, moving back and forth between the bedroom and the main room, and no staff was observed standing next to the client. During an interview on 12/05/2025 at 11:35 AM, the House Manager acknowledged that staff should always be with Client #5 and that the client must wear a gait belt during ambulation. The Qualified Intellectual Disabilities Professional who was also present confirmed that staff should	W 251	On 12/22/25 & 01/18/26, the DCHC Physical Therapist retrained all staff on on proper use of a gait belt and the requirement to provide standby supervision during ambulation. The HM & QIDP will monitor implementation of the program daily for one month and will continue ongoing staff training as needed. Please see Attachment "A1 & A2"	12/22/25 & 01/18/26

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W 251	Continued From page 3 stand next to the client, and that the gait belt must be worn when the client is awake and ambulating.	W 251		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that medications were administered in accordance with the physician's orders for one of the five clients residing in the facility (Client #5). Findings Included: The review of Client #5's December 2025 Physician's Orders Sheet (POS) revealed an order for Polyethylene Glycol powder 3350, 510 gm, 17.0 scoop to be administered orally once daily at 6:00 PM. Observations during the morning medication administration pass on 12/03/2025 at 7:06 AM showed that the Licensed Practical Nurse (LPN #1) measured Polyethylene Glycol powder, mixed it with water in a cup, and offered it to Client #5, who consumed the medication with other pills. On 12/05/2025 at 9:00 AM, a review of Client #5's Medication Administration Record (MAR) showed a documentation that Client #5 received the Polyethylene Glycol powder in the evening of 12/03/2025, and not during the morning medication administration. During an interview on 12/05/2025 at 1:20 PM	W 368		

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W 368	Continued From page 4 when asked why Client #5 received Polyethylene Glycol powder in the morning instead of the prescribed 6:00 PM, LPN #1 stated he did not remember administering the medication in the morning on 12/03/2025, and that the medication was administered in the evening.	W 368	On 12/05/25, the LPN was retrained by the RN on how to administer medication by following the physicians order & three way check prior to administering medication. Attachment "C1"	12/05/25

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E 000	Initial Comments An emergency preparedness survey was conducted at this facility from December 03, 2025, through December 05, 2025. The survey findings determined that the facility was in substantial compliance with the requirements of Emergency Preparedness Requirements for Medicare and Medicaid Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). No deficiencies were cited.	E 000		

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