

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/12/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

D C HEALTH CARE

**248 WALNUT STREET, NW
WASHINGTON, DC 20012**

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I 000	Initial Comments A licensure survey was conducted at this Community Residence Facilities for Persons with Intellectual Disabilities (CRFPID) from 12/10/2025 through 12/12/2025. A sample of two persons was selected from a census of four. The findings of the survey were based on observations, interviews, and a review of records.	I 000		
I6570	3504.16 Meals And Dining 3504.16 Each CRFPID shall train the staff in the use of proper mealtime protocols and how to assist persons who require special mealtime protocols or utensils. This Statute is not met as evidenced by: Based on observations, interviews and record reviews, the Community Residence Facilities for Persons with Intellectual Disabilities (CRFPID) failed to ensure six of seven Direct Support Professionals (DSPs #1, #2, #3, #4, #5 and #6), House Manager (HM), Registered Nurse (RN), Licensed Practical Nurse (LPN) and the Program Assistant (PA) interviewed received initial and ongoing training regarding each clients support needs (unbreakable curved coated tablespoon), for one of the two clients in the core sample (Person #2) with hand contractures. Findings included: Observations during dinner on 12/10/2025 at 6:03 PM showed that Person #2 was served pureed mixed vegetables, baked chicken and brown rice in a divided plate. Direct Support Professional (DSP) #3 fed the Person the entire meal using a regular tablespoon.	I6570		

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Program Director

(X6) DATE

12/29/25

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I6570	Continued From page 1 On 12/11/2025 at 7:25 AM, observations during breakfast showed Person #2 was served pureed raisin bran and whole wheat bagel with cream cheese in a divided plate for breakfast. DSP #7 was observed scooping food onto an unbreakable curved coated tablespoon, placed the spoon in Person #2's right hand and verbally prompted the Person to feed herself. The Person was able to secure the curved tablespoon and place the food in her mouth, and this continued throughout breakfast which finished at 7:50 AM. During an interview at 10:03 AM regarding Person #2 using an unbreakable curved coated tablespoon during breakfast, the Qualified Intellectual Disabilities Professional (QIDP) stated that " I handed the spoon to DSP #7 to use and was surprised the Person grabbed the spoon and fed herself." At 11:12 AM, the review of two inservice records provided by the QIDP revealed that six of seven DSPs, the House Manager, the Registered Nurse (RN), the Licensed Practical Nurse (LPN) and the Program Assistant (PA) all received training on Person #2's mealtime protocol which includes the use of adaptive equipment on 12/10/2025 and 12/11/2025. There was no other prior training available for review regarding Person #2's mealtime protocol. Again at 12:54 PM, Person #2 was observed feeding herself with staff assistance during lunch using the unbreakable curved tablespoon. DSP #7 during an interview at 1:00 PM confirmed that Person #2 participates in feeding herself with the curved tablespoon with staff encouragement.	I6570			

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I6570	Continued From page 2 On 12/12/2025 at 11:55 AM, the review of a mealtime protocol dated 12/6/2025 indicated that Person #2 used an unbreakable curved coated tablespoon for eating. Per the protocol, Person #2 required encouragement, reminders and occasional feeding after set-up During a telephone interview at 1:06 PM DSP #3 who fed Person #2 during dinner on 12/10/2025 stated that she was unaware that Person #2 could feed herself using the unbreakable curved coated tablespoon with some assistance from staff prior to 12/10/2025. DSP #3 acknowledged receiving training provided by the QIDP with other staff during the survey period on 12/10/2025 and 12/11/2025. Note: It should be noted that six of seven DSPs, the Registered Nurse (RN), the Licensed Practical Nurse (LPN), House Manager (HM) and Program Assistant (PA) all confirmed that they were unaware that Person #2 could participate with encouragement and some physical assistance using the unbreakable curved coated tablespoon.	I6570	<i>An In service training was done on 12/17/25 by the QIDP with the staff on following strategies outlined on Client #2's Mealtime protocol and proper use of adaptive equipment.</i> <i>Furthermore a training was done with DCHC QIDPs by Program Director on 12/18/25 on DCHC Policy of coordination of information of all persons under our care with care team including Day Program.</i> <i>Program Director/ QA will do random review to ensure proper implementation of the same.</i> <i>Please see "Attachment A1 & A2 & C"</i>	12/17/25 & 12/18/25
I6810	3505.11 BEDROOMS 3505.11 Each person shall have privacy in his or her sleeping and living unit. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the Community Residence Facilities for Persons with Intellectual Disabilities (CRFPID) failed to ensure privacy during personal needs and medication administration preparation, for four of the four clients residing in the facility	I6810		

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I6810	Continued From page 3 (Clients #1, #2, #3 and #4). Finding included: a) Observations on 12/10/2025 at 6:15 PM showed Person #4 walked into the bathroom with Direct Support Professional (DSP) #4(client's assigned one-to-one) behind the person. Without closing the bathroom door, the Person pulled her pants down and sat on the toilet while DSP #4 went inside Person #1's bedroom right beside the bathroom. While walking to pass the bathroom to get to Person #1's bedroom for evening medication administration, the Licensed Practical Nurse (LPN) and surveyor observed Person #4 seated on the toilet with the door wide open. DSP #4 then walked out of the bedroom, noticed that the bathroom door was wide open and closed the bathroom door halfway still exposing the Person still sitting on the toilet. During an interview at 6:50 PM, DSP #4 was asked if Person #4 could close the bathroom door during personal care needs, and DSP #4 stated that you have to encourage the Person to do so. DSP #4 stated "I left a crack in the door because sometimes Person #4 do like to the bathroom door to be shut completely and remained close to the door so that the person knew I was there." DSP #4 also confirmed receiving training on Person privacy. On 12/12/2025 at 10:35 AM, a review of the facility's staff inservice training records revealed that on 06/13/2025 all the staff were trained in Privacy during bathroom use including DSP #4. b) Observations on 12/11/2025 at 6:55 AM, revealed that the LPN retrieved Person #2's medication from the medication cart drawer and	I6810			

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I6810	Continued From page 4 began to prepare the clients medications on top of the medication cart located in the dining/kitchen area. Continued observation showed that there were other staff DSPs walking through the kitchen/dining area while the LPN prepared the clients' medications. During an interview at 10:28 AM, the LPN was asked about privacy during medication administration pass. The LPN acknowledged receiving training on maintaining privacy while preparing and administering medications to the clients. On 12/12/2025 at 12:13 PM, a review of the facility's inservice training records dated 05/27/2025 confirmed that the LPN had received training on Person privacy during medication preparation and administration.	I6810	<i>An In service training was done with DCHC RNs & LPNs by Program Director on 12/18/25 on DCHC Policy of medication administration & Persons Privacy during the process.</i> <i>Program Director/ QA will do random review to ensure proper implementation of the same.</i> <i>Please see "Attachment D"</i>	12/18/25
I8110	3514.1 QUALIFIED INTELLECTUAL DISABILITIES PRO(QIDP) 3514.1 The QIDP shall oversee the initial admission assessments of persons, participate in the development of the ISP and monitor, integrate and coordinate services. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate, integrate and monitor each client's day program services, for one of the two clients in the core sample (Person #2). Findings included:	I8110		

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I8110	Continued From page 5 Observations during lunch at the day program on 12/12/2025 at 11:50 AM showed that Person #2 was served a pureed grilled cheese sandwich on wheat bread, vegetable soup and mandarin oranges in a divided plate. Continued observations showed that the Day Program Staff (DPS) failed to encourage the Person to feed herself using the unbreakable curved coated fed tablespoon and fed the client. On 12/12/2025 at 11:55 AM, the review of a mealtime protocol dated 12/6/2025 indicated that Person #2 used an unbreakable curved coated tablespoon for eating. Per the protocol, Person #2 required encouragement, reminders and occasional feeding after set-up. When asked during an interview at 12:55 PM, the DPS and Day Program Coordinator (DPC) both stated that Person #2 could not feed herself and was totally dependent on staff for feeding. The surveyor shared that observations at the facility revealed the Person feeding herself with assistance during breakfast and dinner meal, using the unbreakable curved coated tablespoon. The DPS then placed the curved coated tablespoon in Person #2's right hand with assistance from another staff and the Person fed herself. During further interview, the DPC stated that the day program was unaware that Person #2 was able to feed herself and that this information was never shared with the program by the facility's Qualified Intellectual Disabilities Professional (QIDP). The DPS also stated that this was the first time the facility placed the unbreakable curved coated tablespoon inside the clients lunch bag instead of a regular tablespoon.	I8110		

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I8110	Continued From page 6 The QIDP on 12/12/2025 at 1:57 PM, when asked if the day program was aware that Person #2's could feed herself with assistance using the unbreakable curved coated tablespoon in accordance with the mealtime protocol, stated "the day program could retrieve Person #2's mealtime protocol from the MCIS system and implement the protocol". Further interview confirmed that the QIDP was unaware that the day was not using the unbreakable curved coated tablespoon at the day program as required. The QIDP also acknowledged that she had not provided training to the day program staff regarding Person #2's use of adaptive curved coated tablespoon.	I8110	<i>An In service training was done on 12/17/25 by the QIDP with the staff on following strategies outlined on Client #2's Mealtime protocol and proper use of adaptive equipment.</i> <i>Furthermore a training was done with DCHC QIDPs by Program Director on 12/18/25 on DCHC Policy of coordination of information of all persons under our care with care team including Day Program.</i> <i>Program Director/ QA will do random review to ensure proper implementation of the same.</i> <i>Please see "Attachment A1 & A2 & C"</i>	12/17/25 & 12/18/25