DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G178	A. BUILDING _____ B. WING _____	08/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1307 45TH PLACE, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from August 26, 2010 through August 27, 2010, utilizing the fundamental survey process. A random sampling of two clients was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with one family member, group home/day program staff, and the review of clinical and administrative records, including incident/investigation reports.	W 000	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 9-20-10	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an effective system to protect the clients' right for privacy during medication administration, for three of the four clients residing in the facility. (Client #2, #3 and #4) The finding includes: Observations during medication administration on August 26, 2010, from 6:30 a.m. until 6:50 a.m. revealed LPN #1 administering Client #2's medications in front of Client #1. Further observation revealed Client #3 and Client #4 being administered their medications in front of Client #2. When interviewed at approximately 6:55 a.m., LPN #1 acknowledged that Clients #2,	W 130	t is the policy of this Provider that privacy be provided during the medication administration. To ensure privacy during the medication administration, each facility has a designated area where each individual is given the medication out of the presence of the other individuals; however, the LPN who administered the medication on August 26, 2010 at 6:30am failed to provide privacy during the medication administration. The LPN who administered the medication was inserviced by the DON on Refer to attachment #1. In the future, the agency will ensure that the nurses provide privacy during the medication administration. To prevent this situation to re-occur, the LPN supervisor will monitor the medication pass once monthly, and the RN supervisor will monitor the medication pass on a quarterly basis as stipulated on the medication policy. Refer to the attached policy.	8-31-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Ekwuno	Program Director	9-10-10

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 130	Continued From page 1 #3 and #4 was not provided privacy during medication administration. There was no evidence that staff ensured privacy during medication administration.	W 130		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its policies to ensure the health and safety for two of four clients residing in the facility. (Clients #2 and #6)3 The finding includes: Cross-refer to W154. The facility failed to implement its policy for investigating all reportable and serious reportable incidents.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to investigate serious reportable incidents to ensure the health and safety of two of four clients residing in the facility. (Clients #2 and #3) The findings include:	W 154	This provider has an Incident Management Policy that prohibits mistreatment, neglect or abuse of the individuals. It is also the the Policy of this provider that all of the incidents are reported on a timely manner, and investigated.	

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W 154	Continued From page 2 On August 26, 2010, beginning at 9:18 a.m., review of the facility's unusual incidents and investigations revealed the following: a. On August 22, 2010, while walking to the kitchen to the dining table, Client #2 bumped his head on the side of the entrance to the living room. The client sustained an abrasion to his left eyebrow. Interview with the facility's qualified mental retardation profession (QMRP) on August 27, 2010, at approximately 3:31 p.m., revealed that the potential source of the injury had not been investigated. b. On August 6, 2010, Client #3 arrived home from the day program and was escorted directly to the bathroom by his 1:1 staff. The client pulled his briefs down and a bruise was observed on the right thigh. Interview with the QMRP on August 27, 2010, at approximately 3:45 p.m., revealed that he remembered the incident and began to show the surveyor how the bruise may have occurred to Client #3's right thigh. However, when asked if the incident had been investigated, the QMRP stated that he believe so, but was not able to produce any documentation of it. Review of the facility's incident management policy (IMC) on August 27, 2010, at approximately 3:55 p.m., revealed all that all incidents are investigated. Further review of the IMC revealed that all serious reportable incidents including abuse/neglect and incidents of unknown origin shall be investigated by the facility beginning within 12 hours after witnessed or discovered. At the time of the survey, there was no documented evidence that the aforementioned incidents had been investigated.	W 154	It is also the the Policy of this provider that all of the incidents are reported on a timely manner, and investigated. The QIDP did follow the incident management protocol. The incident report was completed on a timely manner, but the QIDP did not complete the investigation as stipulated on the incident management policy. Refer to attachment # 2 The QIDP was inserviced by the IMC on Refer to attachment # In the future, the provider will ensure that all investigations are completed as stipulated in the Incident Management Policy. The IMC will verify that all the incidents are investigated, sent to the entities, and filed. b. It is also the the Policy of this provider that all of the incidents are reported on a timely manner, and investigated. The QIDP did follow the incident management protocol. The incident report was completed on a timely manner, but the QIDP did not complete the investigation as stipulated on the incident management policy. This incident report was faxed to DOH on Refer to attachment # 2 The QIDP was inserviced by the IMC on Refer to attachment # 2 In the future, the provider will ensure that all investigations are completed as stipulated in the Incident Management Policy. The IMC will verify that all the incidents are investigated, sent to the entities, and filed.	8-31-10 9-14-10 8-31-10

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W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident for one discharged client. (Client #1) The finding includes: Review of an incident report dated March 17, 2010 on August 26, 2010, at approximately 9:30 a.m., revealed Client #1 sustained a physical injury above his left eyebrow. Review of Client #1's hospital "Discharge Instructions" dated March 17, 2010, revealed the client's diagnoses included an abrasion to the face. Review of the corresponding investigative report dated March 17, 2010, on August 26, 2010 at approximately 9:55 a.m., revealed that the Qualified Mental Retardation Professional (QMRP) completed the investigation on March 21, 2010. Further review revealed the administrator had not reviewed and signed the investigative report. Interview with the Supervisory LPN on August 26, 2010, at approximately 2:30 p.m., it was acknowledged the administrator had not reviewed and signed the investigative report. There was no documented evidence at the time	W 156	It is also the the Policy of this provider that all of the incidents are reported on a timely manner, investigated. All of the investigation reports must be reviewed, and signed by the administration. The Incident Management Coordinator failed to have the investigation report dated March 17, 2010 to be reviewed, and signed by the administration. The IMC was inserviced by the Program Director on the investigation protocol on 8-31-10 Refer to attachment #3 In the future, the Incident Management Coordinator will ensure that all of the investigative reports are signed, and reviewed by the administration.	

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W 156	Continued From page 4 of the survey the results of all investigations was reported to the administrator within five working days of the incident.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for one of the two clients residing in the sample. (Client #1) The finding includes: Review of Client #1's hospital discharge summary dated July 6, 2010, on August 26, 2010, at approximately 10:00 a.m., revealed Client #1 had been hospitalized with diagnoses that included dehydration and right lower lobe infiltration. Further review revealed a recommendation to reduce the salt intake in the client's diet. In an interview with the Supervisory LPN on August 26, 2010, at approximately 10:20 a.m. it was acknowledged that the interdisciplinary team (IDT was not made aware of the hospital discharge summary's recommendation. There was no documented evidence the QMRP coordinated, integrated, and monitored all services for the client.	W 159	The hospital discharge recommended diet change to Low Salt; The PCP was made aware of this change, and agreed with the plan. Client #1 had a follow-up visit with the PCP on 7-7-10. The PCP issued an order for the diet change, and the change was implemented, but the nurse did not place the POS on file. The nutritionist was made aware of the recommendations as well. Refer to attachment #. 5 In the future, the facility management will ensure that all records pertaining to any recommendations are placed on the individual's records, and available upon request.	
W 331	483.460(c) NURSING SERVICES	W 331		

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W 331	Continued From page 5 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for four of four clients in the facility. (Client # 1, #2, #3 and Client # 4) The findings include: 1. [Cross-refer to W130] The facility's nursing staff failed to ensure an effective system to protect the clients' right for privacy during medication administration. 2. [Cross-refer to W455] The facility's nursing staff failed to ensure consistent implementation of an active program for the prevention and control of infection for the clients.	W 331	Refer to W 130 P.1 of 8 Attachment #1.a Refer to W 455 P.7of 8 Attachment # 1.b	8-31-10 8-31-10
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD Is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that client's received dental services in a timely manner, for one of two sampled clients. (Client #2)	W 356		

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W 356	Continued From page 6 The finding includes: Observations conducted at the day program on August 26, 2010, at 12:26 p.m., revealed Client #1 was observed to have missing teeth and some discoloration as he sat at the activity table with his 1:1 staff and classmates. Review of Client #2's medical record on August 27, 2010, at approximately 9:58 p.m., revealed a dental consult dated January 20, 2010. According to the consult, the findings revealed "heavy calculus deposits" and recommended the patient needs full mouth scaling with sedation... will submit pre-authorization to Medicaid... will call to reschedule once returned. It should be noted that the last documented time Client #2 received dental treatment was on July 23, 2009. Interview with the facility's Licensed Practical Nurse (LPN) on August 27, 2010, at approximately, 10:05 a.m., revealed that she had made several calls to the dental office but had not received a response since Client #2's last visit on January 20, 2010. At the time of the survey, the facility failed to ensure Client #2 received timely dental services (full mouth scaling).	W 356	Client #2's dental scaling was delayed because his preauthorization for scaling was still pending, and was not received by dentist yet. The facility nurse expressed concerns on delays in dental services to DCHRP nurse, who advised the facility to continue to contact the dentist's office for appointment, and document response. On 9-14-2010, the facility nurse called the dentist office who stated that currently, the procedure to obtain scaling treatment requires the individual to have completed the following 1. Peridontal Probeing 2. Panoramic X-ray The dentist's will call to make the appointment once medicaid authorizes the scaling. In the future, the facility's nurse will ensure that the individuals dental care is provided on a timely manner.	
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and	W 455		

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W 455	Continued From page 7 communicable diseases, for one of four clients residing at the home. (Client #2) The finding includes: On August 26, 2010, at approximately 6:30 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse her hands prior to mixing carnation instant breakfast in a cup of milk for Client #2. However, LPN #1 touched the refrigerator door handle, cabinet counter and then the rim of the cup of milk prior to giving the cup to Client #2. During a face to face interview with LPN #1 on August 26, 2010, at approximately 6:35 a.m., it was acknowledged she touched the rim of the cup of milk when giving the cup to Client #2 after touching the refrigerator door handle and cabinet counter. There was no evidence the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	As stipulated on the nursing policy, the nurses must wash their hands before dispensing medications, and the infection control must be maintained through the entire process. LPN #1 was inserviced by the DON on Refer to attachment #1.b In the future, the med pass nurse will ensure that the prevention of infection controlled is maintained during the entire medication administration process. The LPN should use the clean and dry towel to open the refrigerator.. She must hold the cup/glass by the middle or bottom to avoid contamination to the rim.	8-31-10

Health Regulation Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 26, 2010 through August 27, 2010. A random sampling of two residents was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with one family member, group home/day program staff, and the review of clinical and administrative records, including incident/investigation reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors for four of four clients residing in the facility. (Clients #1, #2, #3, and #4) The findings include: 1. The front entrance walkway had broken concrete, which could be considered a trip hazard. 2. There were bricks in the front yard next to the	I 090	The broken concrete at front entrance walkway is being repaired. In the future, the facility management will ensure that the front entrance walkway is in good repair in order to prevent the trip hazard. The bricks in the front yard next to the front	8-27-10

Angela Enyioha — TITLE: Program Director — (X6) DATE: 9-17-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 090	Continued From page 1 front porch wall that served no purpose. The quality assurance assistant (QAA) explained they were left when the landscaping was changed. (The bricks were removed prior to the exit conference that day). Interior: 3. In the living room behind the chair, chipping and peeling paint was observed on the wall. 4. The carpet located on the hallway floor before entering the bathroom was observed to have a tear in it which could be considered as a trip hazard. 5. In the bathroom located near the bedrooms on the first floor, the toilet safety guard was observed to have built up rust on it. The vent located in the same bathroom was also observed with rust. 6. In residents #3 and #4's bedroom, the closet ceiling was observed to have water stains. These deficiencies were acknowledged by the QAA during this inspection.	I 090	front porch were removed on In the future, the facility management will ensure that the bricks in the front yard that serve no purpose are removed from the front yard. 3. The chipping and peeling paint behind the chair in the living room were repaired In the future, the facility will ensure that all paintings on the walls show no sign degradation. 4. The tear on the carpet located on the hallway floor before entering the bathroom was repaired In the future, the facility will ensure that the carpet around the house is in good repair, to prevent the tripping hazard. 5. The rusted toilet seat and vent were replaced In the future, the facility management will ensure that all bathroom toilet seats and vents are in good repair. 6. The ceiling in resident #3 and 4's bathroom closet that had water stains was repaired.	8-27-10 9-1-10 9-2-10 9-2-10 9-2-10
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by:	I 206		

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I 206	Continued From page 2 Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure that all employees had current health certificates, for two of the thirteen staff (Staff #1 and #3) and one of fourteen consultants. (Consultant #13) The finding includes: On August 27, 2010, beginning at approximately 3:45 p.m., review of the personnel records revealed the GHMRP failed to provide evidence that current health certificates were on file for two of fourteen staff (Staff #1 and #3) and two consultants (Consultant #13) The qualified mental retardation professional acknowledged the findings at approximately 4:30 p.m.	I 206	The health certificates for staffing #1and # 3 as wells as consultant #13 are currently on file. Refer to attachment # 4 In the future, the HR department will ensure that all employees' files are up to date, and that record are available upon request.	9-9-10
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to ensure effective training on infection control, for one of four residents residing at the home. (Resident #2) The finding includes: On August 26, 2010, at approximately 6:30 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse her hands	I 226		

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I 226	Continued From page 3 prior to mixing carnation instant breakfast in a cup of milk for Resident #2. However, LPN #1 touched the refrigerator door handle, cabinet counter and then the rim of the cup of milk prior to giving the cup to Resident #2. During a face to face interview with LPN #1 on August 26, 2010, at approximately 6:35 a.m., it was acknowledged she touched the rim of the cup of milk when giving the cup to Resident #2 after touching the refrigerator door handle and cabinet counter. There was no evidence the facility's nursing staff provided an active program for the prevention and control of infection.	I 226	As stipulated on the nursing policy, the nurses must wash their hands before dispensing medications, and the infection control must be maintained through the entire process. LPN #1 was inserviced by the DON on Refer to attachment #1.b In the future, the med pass nurse will ensure that the prevention of infection controlled is maintained during the entire medication administration process. It is the policy of this Provider that privacy be provided during the medication administration. To ensure privacy during the medication administration, each facility has a designated area where each individual is given the medication out of the presence of the other individuals; however, the LPN who administered the medication on August 26, 2010 at 6:30am failed to provide privacy during the medication administration. The LPN who administered the medication was inserviced by the DON on Refer to attachment #1. In the future, the agency will ensure that the nurses provide privacy during the medication administration. To prevent this situation to re-occur, the LPN supervisor will monitor the medication pass once monthly, and the RN supervisor will monitor the medication pass on a quarterly basis as stipulated on the medication policy. Refer to the attached policy.	8-31-10 8-31-10
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to ensure staff were effectively trained on resident's rights to privacy for three of four residents living in the facility. (Residents #2, #3 and #4) The finding includes: Observations during medication administration on August 26, 2010, from 6:30 a.m. until 6:50 a.m. revealed Licensed Practical Nurse #1 (LPN #1) administering Resident #2's medications in front of Client #1. Further observation revealed Resident #3 and Resident #4 being administered	I 228		

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0179	A. BUILDING _____ B. WING _____	08/27/2010

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I 228	Continued From page 4 their medications in front of Resident #2. During an interview with the LPN #1 on August 26, 2010, at approximately 6:55 a.m., it was acknowledged that Residents #2, #3 and #4 was not provided privacy during medication administration. There was no evidence that staff ensured privacy during medication administration.	I 228		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the four residents residing in the facility. (Resident #1) The finding includes: On August 26, 2010, beginning at 9:18 a.m.,	I 379	It is also the the Policy of this provider that all of the incidents are reported on a timely manner, and investigated. The QIDP did follow the incident management protocol. The incident report was completed on a timely manner, but the QIDP did not complete the investigation as stipulated on the incident management policy. This incident report was faxed to DOH on Refer to attachment # The QIDP was inserviced by the IMC on Refer to attachment # In the future, the provider will ensure that all investigations are completed as stipulated in the Incident Management Policy. The IMC will verify that all the incidents are investigated, sent to the entities, and filed.	9-14-10 8-31-10

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I 379	Continued From page 5 review of the facility's unusual incidents/investigations revealed an incident dated August 6, 2010. According the incident, Resident #3 arrived home from the day program and was escorted directly to the bathroom by his 1:1 staff. The client pulled his briefs down and a bruise was observed on the right thigh. Interview with the qualified mentaly retardation professional (QMRP) on August 27, 2010, at approximately 3:45 p.m., revealed that he remembered the incident and began to show the surveyor how the bruise may have occurred to Client #3's right thigh. Further interview with the QMRP acknowledges that according to the incident report, DOH/HRLA had not been notified of the incident.	I 379	It is also the the Policy of this provider that all of the incidents are reported on a timely manner, and investigated. The QIDP did follow the incident management protocol. The incident report was completed on a timely manner, but the QIDP did not complete the investigation as stipulated on the incident management policy. This incident report was faxed to DOH on Refer to attachment # 2 The QIDP was inserviced by the IMC on Refer to attachment # 2 In the future, the provider will ensure that all investigations are completed as stipulated in the Incident Management Policy. The IMC will verify that all the incidents are investigated, sent to the entities, and filed.	9-14-10 8-31-10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of one of two sampled residents. (Resident #2) The finding includes: Observations conducted at the day program on August 26, 2010, at 12:26 p.m., revealed Resident #1 was observed to have missing teeth	I 401		

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I 401	Continued From page 6 and some discoloration as he sat at the activity table with his 1:1 staff and classmates. Review of Resident #2's medical record on August 27, 2010, at approximately 9:58 p.m., revealed a dental consult dated January 20, 2010. According to the consult, the findings revealed "heavy calculus deposits" and recommended the patient needs full mouth scaling with sedation... will submit pre-authorization to Medicaid... will call to reschedule once returned. It should be noted that the last documented time Resident #2 received dental treatment was on July 23, 2009. Interview with the GHMRP's Licensed Practical Nurse (LPN) on August 27, 2010, at approximately, 10:05 a.m., revealed that she had made several calls to the dental office but had not received a response since Resident #2's last visit on January 20, 2010. At the time of the survey, the GHMRP failed to ensure Resident #2 received timely dental services (full mouth scaling).	I 401	Client #2's dental scaling was delayed because his preauthorization for scaling was still pending, and was not received by dentist yet. The facility nurse expressed concerns on delays in dental services to DCHRP nurse, who advised the facility to continue to contact the dentist's office for appointment, and document response. On 9-14-2010, the facility nurse called the dentist office who stated that currently, the procedure to obtain scaling treatment requires the individual to have completed the following 1. Peridontal Probeing 2. Panoramic X-ray The dentist's will call to make the appointment once medicaid authorizes the scaling. In the future, the facility's nurse will ensure that the individuals dental care is provided on a timely manner.	