

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2012
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NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20011
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from August 27, 2012 through August 29, 2012. A sample of three clients was selected from a population of four women and one man with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and two day programs, interviews with a client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS

W 125

The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the rights of each client to be free from restraint, for one of the three clients in the sample. (Client #2)

The finding includes:

Received 10/16/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marie Angela Blum</i>	TITLE <i>Program Director</i>	(X6) DATE <i>10-16-12</i>
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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 125 Continued From page 1
[Cross-refer to W268] On August 27, 2012, observation at 8:02 a.m. revealed Client #2 seated in a wheelchair in the living room, with the seat belt fastened. The client remained in the wheelchair until 8:50 a.m., when the client was observed eating breakfast in the dining room. At approximately 9:35 a.m., the facility's program director (Staff #10), program coordinator (Staff #4) and the licensed practical nurse (LPN) coordinator (Staff #8) stated that Client #2 could walk with staff assistance. Staff were to use a gait belt and the wheelchair was used for traveling long distances in the community or for medical appointments. For the remainder of the survey, the client was observed to ambulate with staff assistance using her gait belt.

On August 29, 2012, interviews with Staff #7 (at 8:38 a.m.) and Staff #2 (at 9:15 a.m.) revealed that Client #2 was placed in the wheelchair with the seat belt fastened in order to prevent the client from walking alone when staff were working elsewhere in the facility and unavailable to assist the client with ambulation. They explained that the client was at risk of falls and required direct physical assistance from staff when ambulating. Staff #2 indicated that this was not the first time the client had been placed in the wheelchair to prevent her from ambulating while staff were not present.

On August 28, 2012, at 4:30 p.m., review of Client #2's Individual Support Plan (ISP) dated November 10, 2011, identified the use of a padded gait belt for safety while ambulating as well as the wheelchair to be "used only for extended outings." Facility staff were to "encourage <client's name> to ambulate to

W 125
As per PT's recommendations, individual # 2 must use the wheelchair for extended community outings.
Refer to attachment #1
On August 27, 2012, the staff placed individual #2 on the wheelchair during breakfast because the armchair was broken over the weekend, and was replaced that day in the afternoon.
Individual #2 was placed on the wheelchair without the HRC approval
All staff were inserviced by the QIDP on the PT recommendations on 8-30-12
Refer to attachment # 2
The QIDP has contacted the PT on 10-11-12 to clarify the use of the gait belt.
To promote growth and independence, the PT recommendations will indicate the circumstances in which the gait belt should be used.
In the future, the QIDP will ensure that the staff implement the recommendations as prescribed by the consulting professionals, and that all restrictive measures are approved by the agency's HRC prior to their implementation.

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W 125	Continued From page 2 improve... strength and endurance."	W 125	Refer to w. 125 P. 2	8-30-12
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On August 29, 2012, at 10:20 a.m., review of the facility's Human Rights Committee (HRC) minutes from the past 12 months revealed that on October 10, 2011, the HRC reviewed and approved Client #2's adaptive equipment, including the padded gait belt and a wheelchair "for long distances." There was no evidence that the practice of placing Client #2 in a wheelchair and fastening the seat belt to prevent her from ambulating without staff present had been reviewed by the HRC.

W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159
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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, interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the monitoring and coordination of each client's habilitation and active treatment needs, for one of the three clients in the sample. (Client #2)

The finding includes:

The QIDP failed to ensure that Client #2 received a comprehensive occupation therapy (OT) evaluation to address the client's mealtime (oral feeding) needs, as follows:

On August 27, 2012, at 8:50 a.m., a direct support staff (Staff #1) was observed providing

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W 159 Continued From page 3

hand-over-hand assistance while Client #2 ate breakfast. They used a specialized spoon with a black rubber, built-up handle. A few minutes later, Staff #1 was observed spoon feeding the client after the client became resistant to holding the spoon. On August 27, 2012, at 7:06 p.m., the evening nurse (Staff #6) placed a standard, metal handled tablespoon in Client #2's hand. Three times, the client refused to grasp it. The nurse was then observed spoon feeding the mixture of crushed medications and apple sauce, using the metal tablespoon.

Review of Client #2's Speech-Language Evaluation on August 28, 2012, at approximately 10:00 a.m., revealed the consultant documented concerns related to the adaptive spoon. The evaluation, dated August 22, 2012, included the following recommendations: "Re-evaluate by OT <occupational therapist> to improve tonicity and strength in hands to enable <the client> to grasp utensil" and "Reassess suitability of present built-up black rubber handle perhaps OT will trial <sic> a lighter tubed handle. It may encourage resident's active participation in self-feeding."

On August 28, 2012, at 4:50 p.m., review of Client #2's OT records revealed that Consultant #1 had made a similar recommendation for OT assessment on September 28, 2011, 11 months prior to this survey. The client's records, however, showed no evidence that the client's mealtime adaptive equipment needs had been assessed by the OT.

During the August 29, 2012 Exit conference, at approximately 6:15 p.m., the program director (Staff #10) stated she recalled the former QIDP

W 159

It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the former QIDP to reach him, and have him to come to the facility.

Individual #2 was reassessed by the OT on 9-20-12

Refer to attachment #3a

Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed".

The same type of spoon will be used for passing medication as well.

All staff were inserviced by the OT on 9-21-12

Refer to attachment #3b

In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility. The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals.

Additionally, to prevent the delay in services, if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.

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W 159 Continued From page 4
(QIDP through July 2012) mentioned having spoken with the OT regarding the need to assess the adaptive spoon. She could not, however, offer an explanation as to why the client's OT records did not reflect the use of a spoon with a black built-up handle or assessment of the client's mealtime needs.

W 159

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

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 observation, staff interview and record review, the facility failed to ensure staff was effectively trained to manage the provisions outlined in each client's mealtime protocol, for one of the three clients in the sample. (Client #2)

The findings include:

Facility staff failed to use a teaspoon when spoon feeding Client #2, as recommended by the Speech-Language Pathologist (Consultant #1), as follows:
[Cross-refer W159]

1. On August 27, 2012, at 8:50 a.m., a direct support staff (Staff #1) was observed providing hand-over-hand assistance while Client #2 ate her (pureed) breakfast. They used a tablespoon with a black rubber, built-up handle. However, a few minutes later, Staff #1 was observed spoon feeding the client with the same spoon after the client became resistant to holding the spoon.

It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the previous QIDP to reach him, and have him to the facility.
Individual #2 was reassessed by the OT on 9-20-12
Refer to attachment #3a
Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed".
The same type of spoon will be used for passing medication as well.
All staff were inserviced by the OT on 9-21-12
Refer to attachment #3b
In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility.
The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals; additionally, to prevent the delay in services if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.

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W 189 Continued From page 5

2. On August 27, 2012, at 7:06 p.m., the evening nurse (Staff #6) placed a standard, metal handled tablespoon in Client #2's hand. Three times, the client refused to grasp it. The nurse was then observed spoon feeding the mixture of crushed medications and apple sauce, using the tablespoon.

Review of Client #2's Speech-Language Evaluations (dated August 22, 2012 and September 28, 2011) on August 28, 2012, at approximately 10:00 a.m., revealed the consultant recommended using the black rubber handled tablespoon if/when Client #2 was participating in hand-over-hand feeding. The consultant, however, recommended use of a "normal teaspoon" if/when the client is fed by staff..."teaspoon (not Tablespoon) ...is smaller and easier to control quantity" of food being presented.

On August 29, 2012, at 5:58 p.m., review of the facility's staff in-service training records revealed that on August 8, 2012, the qualified intellectual disabilities professional presented training on clients' adaptive equipment. A signature sheet documented the attendance of both Staff #1 and Staff #6 for the training. Observations made at breakfast on August 26, 2012 and during that evening's medication administration revealed that the training had not been effective.

W 268 483 450(a)(1)(i) CONDUCT TOWARD CLIENT

These policies and procedures must promote the growth, development and independence of the client.

W 189

It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the previous QIDP to reach him, and have him to the facility.

Individual #2 was reassessed by the OT on 9-20-12
Refer to attachment #3a

Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed". The same type of spoon will be used for passing medication as well.

All staff were inserviced by the OT on 9-21-12
Refer to attachment #3b

In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility. The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals; additionally, to prevent the delay in services if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.

W 268

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W 268 Continued From page 6

W 268

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, facility staff failed to consistently promote client independence and choice, for one of the three clients in the sample. (Client #2)

The finding includes:

On August 27, 2012, observation at 8:02 a.m. revealed Client #2 seated in a wheelchair in the living room, with the seat belt fastened. The client remained in the wheelchair until 8:50 a.m., when the client was observed eating breakfast in the dining room. At approximately 9:35 a.m., the facility's program director (Staff #10), program coordinator (Staff #4) and the licensed practical nurse (LPN) coordinator (Staff #8) stated that Client #2 could walk with staff assistance. Staff were to use a gait belt and the wheelchair was used for traveling long distances in the community or for medical appointments. For the remainder of the survey, the client was observed to ambulate with staff assistance using her gait belt.

While being interviewed in the facility on August 29, 2012, at 8:38 a.m., an LPN (Staff #7) that worked the overnight shift stated that staff placed Client #2 in the wheelchair because the client could walk. According to Staff #7, direct support staff would place the client in the wheelchair and buckle the seat belt when they had to work elsewhere in the facility, to ensure the client's safety. He further explained that one of the client's behaviors was to walk about the facility.

The two direct support staff (Staff #1 and Staff

As per PT's recommendations, individual # 2 must use the wheelchair for extended community outings.

Refer to attachment #1

On August 27, 2012, the staff placed individual #2 on the wheelchair during breakfast because the armchair was broken over the weekend, and was replaced that day in the afternoon.

Individual #2 was placed on the wheelchair without the HRC approval. All staff were inserviced by the QIDP on the PT recommendations on 8-30-12

Refer to attachment # 2

The QIDP has contacted the PT on 10-11-12 to clarify the use of the gait belt.

To promote growth and independence, the PT recommendations will indicate circumstances in which the gait belt must be used.

In the future, the QIDP will ensure that the staff implement the recommendations as prescribed by the consulting professionals, and that all restrictive measures are approved by the agency's HRC prior to their implementation.

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W 268 Continued From page 7

#2) on duty on the morning of August 27, 2012 were interviewed in the facility on August 29, 2012. At 8:52 a.m., Staff #1 stated Client #2 was placed in the wheelchair for safety. A chair with armrests reportedly broke during the previous week. Staff #1 then stated that Client #2 usually sat "in her chair," and pointed to a tan recliner in the living room. At 9:15 a.m., Staff #2 also reported that a chair with armrests had broken. She then stated that Client #2 could push the chair away from the dining room table and walk. She replied "yes" when asked if the client had been placed in the wheelchair at other times in the past to prevent her from ambulating while staff were not available.

On August 28, 2012, beginning at 3:09 p.m., review of Client #2's physical therapy (PT) records and Individual Support Plan (ISP) dated November 10, 2011, confirmed that the wheelchair was to be used for long distance travel in the community. Staff were to "encourage <client's name> to ambulate to improve... strength and endurance" while using the gait belt.

On August 29, 2012, at 10:20 a.m., review of the facility's Human Rights Committee (HRC) minutes from the past 12 months revealed that on October 10, 2011, the HRC reviewed and approved Client #2's adaptive equipment, including the wheelchair "for long distances." There was no evidence that the practice of placing Client #2 in a wheelchair and fastening the seat belt to prevent her from ambulating without staff present had been reviewed by the HRC.

W 369 483.460(k)(2) DRUG ADMINISTRATION

W 268

As per PT's recommendations, individual # 2 must use the wheelchair for extended community outings.

Refer to attachment #1

On August 27, 2012, the staff placed individual #2 on the wheelchair during breakfast because the armchair was broken over the weekend, and was replaced that day in the afternoon. Individual #2 was placed on the wheelchair without the HRC approval. All staff were inserviced by the QIDP on the PT recommendations on 8-30-12

Refer to attachment # 2

The QIDP has contacted the PT on 10-11-12 to clarify the use of the gait belt.

To promote growth and independence, the PT recommendations will indicate the circumstances in which the gait belt should be used.

In the future, the QIDP will ensure that the staff implement the recommendations as prescribed by the consulting professionals, and that all restrictive measures are approved by the agency's HRC prior to their implementation.

W 369

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W 369 Continued From page 8
The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

W 369

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that all drugs were administered without error, for two of the five clients residing in the facility. (Clients #3 and #5)

The findings include:

The evening medication administration was observed on August 27, 2012, beginning at 5:45 p.m.

1. At approximately 6:05 p.m., a licensed practical nurse (Staff #6) was observed pouring Lactulose stool softener into a small plastic medication cup. He was holding the medication cup in the air with one hand while pouring the Lactulose with the other. Staff #6 stated that he had just poured 15 ml which Client #5 received for constipation and he placed it on the tray with other medications he had prepared for the client. Observation of the medication cup on a level surface, however, revealed approximately 20 ml of Lactulose in it. When informed that there was more than 15 ml in the cup, Staff #6 adjusted it to the correct amount.

At 6:48 p.m., review of physician's order sheets (POS) and medication administration records (MARs) for August 2012 confirmed that Client #5 was prescribed Lactulose 15 ml for constipation.

All LPNs in the facility were inserviced by the RN on 8-29-12 on the tips on Using Measuring Tools for Liquid Medicines, "How do you give liquid medicine at the right amount".
Refer to attachment #4
In the future, the facility nursing management will ensure that the dosage of the liquid medicine is dispensed as prescribed.

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W 369 Continued From page 9
2. At 7:55 p.m., Staff #6 was observed pouring Augmentin (liquid form) into a small plastic medication cup. As he had done earlier that evening, the nurse held the medication cup in the air with one hand while he poured the Augmentin with the other. Staff #6 stated that he had just poured 10 ml which Client #3 received to treat a urinary tract infection. He then placed the cup on the tray with other medications he had prepared for Client #3. Observation of the medication cup on a level surface, however, revealed there was approximately 12 or 13 ml of Augmentin in it. When informed that there was more than 10 ml in the cup, Staff #6 adjusted it to the correct amount.

W 369
All LPNs in the facility were inserviced by the RN on 8-29-12 on the Tips on Using Measuring Tools for Liquid Medicines, "How do you give liquid medicine at the right amount".
Refer to attachment #4
In the future, the facility nursing management will ensure that the dosage of the liquid medicine is dispensed as prescribed.

At 8:05 p.m., review of Client #3's POS and MARs for August 2012 confirmed that the client was prescribed Augmentin 10 ml for UTI.

W 449 483.470(i)(2)(iv) EVACUATION DRILLS
The facility must investigate all problems with evacuation drills and take corrective action.

W 449
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to take corrective action after investigating evacuation drill completion times, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)
The finding includes:
On August 28, 2012, beginning at 9:42 a.m., review of the facility's fire drill evacuation records revealed that staff had documented 61 evacuation drills conducted during the period

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W 449 Continued From page 10
September 1, 2011 - August 31, 2012. Drill reports indicated staff typically completed the drills in 45 minutes. For example, 3 of the 4 drills in September 2011 took 45 minutes to complete; the other one took 40 minutes. The 6 drill reports filed for December 2011 indicated it took staff anywhere from 30 - 65 minutes to complete the evacuation process. Similar evacuation times had been documented for other drills throughout the 12-month period.

Continued review of the fire drill reports revealed staff typically wrote "none" in the space designated for documenting problems encountered during a drill, even when it took 45 or 50 minutes to complete the drill. On a few occasions, however, staff expressed concern about the length of time it took. For example, on September 22, 2011 and October 21, 2011, staff wrote "very slow movement" after documenting that it took them 45 minutes and 46 minutes to evacuate, respectively. On January 19, 2012, staff documented it took 40 minutes to evacuate and wrote (re: problems): "none other than trying to get up 5 individuals and out of the house with only 2 staff." On June 9, 2012, staff documented it took 49 minutes to evacuate and offered one recommendation, as follows: "the ratio for staff to individual."

On August 28, 2012, at 11:23 a.m., review of the facility's Evacuation Plan/Policy dated June 2005 revealed the following: "After each fire drill has been completed, the supervisor will complete a Fire Drill Report Form which indicates the time required to complete the evacuation and any problems encountered during the drill routine. This information will be used by the Facilities

W 449
On average, Dahlia's drills takes approximately 30 minutes and 25 seconds to complete. "Complete" is defined when the individuals and staff are at the specified zone; corner of Dahlia Street and Piney Branch. Dahlia house has five individuals 3 use the wheelchairs, one has a gait belt, and one can walk with the staff assistance. We understand that the "drill" is much different than a true emergency/fire and the evacuation time reflected during drill will be more. The place of gathering has been changed to the closer/safe area. The QIDP is working closely with the staff during the fire drills to ensure that the time is accurately documented. In case of fire, the staff will use the Cradle Drop to pull the individual from the room by mean of a blanket. The pack Strap Carry; individual is carried from behind with hand crossed at a person's neck. Straight chair used as stretchers. **** The Program Coordinator has contacted Dahlia's closest fire Department on September 4, 2012, and spoke with someone from the Department Refer to attachment # 5a. On September 20, 2012, the Program Coordinator has registered Dahlia House on the Website called Smart 911.com Refer to attachment #5b. On Monday, September 24, 2012, the DC Fire Marshals reported to Dahlia House for the annual inspection. The Ward Wide Emergency drill was completed on 9-26-12, and Dahlia House did participate. In the future, all of the drill reports will be presented to the Quarterly Safety Committee for discussion, and evaluation.

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W 449 Continued From page 11
Coordinator to review the need for any changes in the established procedure."

The program director (Staff #10) was interviewed in the facility on August 29, 2012, at 10:44 a.m. She recalled the agency's Safety Committee (meets quarterly) had discussed the issue of evacuation time. When asked if the committee had determined the maximum time allowable, Staff #10 replied "5 - 8 minutes, by 10 minutes." She further stated that the former qualified intellectual disabilities professional (QIDP until July 2012) recommended hiring more staff. The agency filled a staff position vacancy since then but had not increased the staffing ratio. When asked who was the agency's facilities coordinator, Staff #10 stated that position no longer existed and she received the fire drill reports monthly. When informed a moment later that drills routinely took 30 - 55 minutes to complete, Staff #10 indicated that was "too long."

On August 29, 2012, at 1:45 p.m., review of the agency's Safety Committee records revealed that the minutes taken at their April 3, 2012 meeting included the following: We understand that a 'drill' is much different than a true emergency/fire and the evacuation time reflected during drills will be much less." The minutes indicated the facility had "fire doors that can contain the fire and smoke on one side of the house while staff are taking the individuals out (fire side first). There are 3 means of egress..." The minutes reflected discussion regarding a neighbor who had helped during power outages and snowstorms. Lastly, the minutes reflected the following: "The local fire house is not far from the facility, and Dahlia is a 'known' location with medically fragile

W 449
On average, Dahlia's drills takes approximately 30 minutes and 25 seconds to complete. "Complete" is defined when the individuals and staff are at the specified zone; corner of Dahlia Street and Piney Branch. Dahlia house has five individuals 3 use the wheelchairs, one has a gait belt, and one can walk with the staff assistance. We understand that the "drill" is much different than a true emergency/fire and the evacuation time reflected during drill will be more. The place of gathering has been changed to the closer/safe area. The QIDP is working closely with the staff during the fire drills to ensure that the time is accurately documented. In case of fire, the staff will use the Cradle Drop to pull the individual from the room by mean of a blanket. The pack Strap Carry; individual is carried from behind with hand crossed at a person's neck. Straight chair used as stretchers. **** The Program Coordinator has contacted Dahlia's closest fire Department on September 4, 2012, and spoke with someone from the Department Refer to attachment # 5a. On September 20, 2012, the Program Coordinator has registered Dahlia House on the Website called Smart 911.com Refer to attachment #5b. On Monday, September 24, 2012, the DC Fire Marshals reported to Dahlia House for the annual inspection. The Ward Wide Emergency drill was completed on 9-26-12, and Dahlia House did participate. In the future, all of the drill reports will be presented to the Quarterly Safety Committee for discussion, and evaluation.

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W 449	Continued From page 12 individuals...and was assessed when the home was first opened in 2008. Recommendation is to hold an open house for neighborhood first responders. Look to September as an emergency awareness month." The Safety Committee minutes did not reflect determination of the maximum evacuation time allowed for evacuations. At 2:43 p.m., Staff #10 stated that she had just spoken with the former QIDP who reported having telephoned the local fire house twice. Staff #10 reported that review of the visitor's log showed no evidence that "first responders" had come to the facility for an open house At the time of the survey, there was no evidence that facility management had addressed the issue of evacuation times. The aforementioned findings will be referred to the Office of the Fire Marshal for review.	W 449	On average, Dahlia's drills takes approximately 30 minutes and 25 seconds to complete. "Complete" is defined when the individuals and staff are at the specified zone; corner of Dahlia Street and Piney Branch. Dahlia house has five individuals 3 use the wheelchairs, one has a gait belt, and one can walk with the staff assistance. We understand that the "drill" is much different than a true emergency/fire and the evacuation time reflected during drills will be more. The place of gathering has been changed to the closer/safe area. The QIDP is working closely with the staff during the fire drills to ensure that the time is accurately documented. In case of fire, the staff will use the Cradle Drop to pull the individual from the room by mean of a blanket. The pack Strap Carry; individual is carried from behind with hand crossed at a person's neck. Straight chair used as stretchers. **** The Program Coordinator has contacted Dahlia's closest fire Department on September 4, 2012, and spoke with someone from the Department Refer to attachment # 5a. On September 20, 2012, the Program Coordinator has registered Dahlia House on the Website called Smart 911.com Refer to attachment #5b. On Monday, September 24, 2012, the DC Fire Marshals reported to Dahlia House for the annual inspection. The Ward Wide Emergency drill was completed on 9-26-12, and Dahlia House did participate. In the future, all of the drill reports will be presented to the Quarterly Safety Committee for discussion, and evaluation.	

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 27, 2012 through August 29, 2012. A sample of three residents was selected from a population of four women and one man with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with a resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000	<p>It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the previous QIDP to reach him, and have him to the facility.</p> <p>Individual #2 was reassessed by the OT on 9-20-12</p> <p>Refer to attachment #3a</p> <p>Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed".</p> <p>The same type of spoon will be used for passing medication as well.</p> <p>All staff were inserviced by the OT on 9-21-12</p>
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored adaptive equipment and occupational therapy needs timely, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On August 27, 2012, at 8:50 a.m., a direct support staff (Staff #1) was observed providing hand-over-hand assistance while Resident #2 ate</p>	I 180	<p>Refer to attachment #3b</p> <p>In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility.</p> <p>The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals; additionally, to prevent the delay in services if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.</p>

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Marie Angela Spaulding
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director
TITLE

10-16-12
(X6) DATE

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I 180	Continued From page 1 her (pureed) breakfast. They used a specialized spoon with a black rubber, built-up handle. A few minutes later, Staff #1 was observed spoon feeding the resident after the resident became resistant to holding the spoon. On August 27, 2012, at 7:06 p.m., the evening nurse (Staff #6) placed a standard, metal handled tablespoon in Resident #2's hand. Three times, the resident refused to grasp it. The nurse was then observed spoon feeding the mixture of crushed medications and apple sauce, using the metal tablespoon. Review of Resident #2's Speech-Language Evaluation on August 28, 2012, at approximately 10:00 a.m., revealed the consultant documented concerns related to the adaptive spoon. The evaluation, dated August 22, 2012, included the following recommendations: "Re-evaluate by OT <occupational therapist> to improve tonacity and strength in hands to enable <the resident> to grasp utensil" and "Reassess suitability of present built-up black rubber handle perhaps OT will trial <sic> a lighter tubed handle. It may encourage resident's active participation in self-feeding." On August 28, 2012, at 4:50 p.m., review of Resident #2's OT records revealed that Consultant #1 had made a similar recommendation for OT assessment on September 28, 2011, 11 months prior to this survey. The resident's records, however, showed no evidence that the resident's mealtime adaptive equipment needs had been assessed by the OT. During the August 29, 2012 Exit conference, at approximately 6:15 p.m., the program director (Staff #10) stated she recalled the former QIDP (QIDP through July 2012) mentioned having spoken with the OT regarding the need to assess	I 180	It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the previous QIDP to reach him, and have him to the facility. Individual #2 was reassessed by the OT on 9-20-12 Refer to attachment #3a Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed". The same type of spoon will be used for passing medication as well. All staff were inserviced by the OT on 9-21-12 Refer to attachment #3b In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility. The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals; additionally, to prevent the delay in services if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.	

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I 180	Continued From page 2 the adaptive spoon. She could not, however, offer an explanation as to why the resident's OT records did not reflect the use of a spoon with a black built-up handle or assessment of the resident's mealtime needs.	I 180			
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: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates on file, for 1 of the 7 direct support staff (Staff #1) and 3 of the 9 consultants. (Consultant #1, Consultant #2 and Consultant #3) The findings include: On August 28, 2012, beginning at 4:53 p.m., review of the personnel records for all employees, including licensed professional health consultants, revealed the following: 1. Staff #1's file contained a health screening form that did not reflect a physician's certification. It should be noted that the form indicated that a tuberculosis skin test (PPD) had been administered by a nurse practitioner on	I 206			

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I 206	<p>Continued From page 3</p> <p>September 21, 2011, with the results ("negative") documented on the same date, September 21, 2011. At 5:14 p.m., the facility's licensed practical nurse coordinator (Staff #8) examined the form and agreed with the aforementioned findings. She then confirmed that the results of a PPD test should be "read" 2 or 3 days after injection; and,</p> <p>2. There was no evidence of a physician's health inventory/ certificate for the speech/language pathologist (Consultant #1). She did, however, have a documented PPD skin test (results "negative") administered on June 27, 2012; and,</p> <p>3. There was no evidence of a physician's health inventory/ certificate for the occupational therapist (Consultant #2). He did, however, have a documented PPD skin test (results "negative") administered on March 11, 2012; and,</p> <p>4. The physician's health inventory/ certificate on file for the behavior specialist (Consultant #3) had been signed August 19, 2011. There was no evidence that she had returned within 12 months to receive an updated health inventory.</p>	I 206	<p>Staff #1's Health Certificate is currently be on file on 9-27-12</p> <p>In the future, the provider will ensure that all employees' record are updated and provided upon request.</p> <p>Refer to attachment #9</p> <p>The Speech and Language Pathologist's Health Certificate will be completed on 10-05-12</p> <p>However, the PPD is current 6-27-12</p> <p>Refer to attachment # 6</p> <p>The OT's complete Health Certificate will be completed on 9-28-12</p> <p>However, the PPD is current</p> <p>Refer to attachment #7</p> <p>The Behavior specialist's Health Certificate is currently on file. 9-1-12</p> <p>Refer to attachment # 8</p> <p>In the future, the provider will ensure that all the employees' record are up to date, and provided upon request.</p>	
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I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with</p>	I 229		
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I 229	<p>Continued From page 4</p> <p>intellectual disabilities (GHPID) failed to ensure that staff received effective training on residents' mealtime adaptive equipment needs, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Facility staff failed to use a teaspoon when spoon feeding Resident #2, as recommended by the Speech-Language Pathologist (Consultant #1), as follows: [Cross-refer I180]</p> <p>1. On August 27, 2012, at 8:50 a.m., a direct support staff (Staff #1) was observed providing hand-over-hand assistance while Resident #2 ate her (pureed) breakfast. They used a tablespoon with a black rubber, built-up handle. However, a few minutes later, Staff #1 was observed spoon feeding the resident with the same spoon after the resident became resistant to holding the spoon.</p> <p>2. On August 27, 2012, at 7:06 p.m., the evening nurse (Staff #6) placed a standard, metal handled tablespoon in Resident #2's hand. Three times, the resident refused to grasp it. The nurse was then observed spoon feeding the mixture of crushed medications and apple sauce, using the tablespoon.</p> <p>Review of Resident #2's Speech-Language Evaluations (dated August 22, 2012 and September 28, 2011) on August 28, 2012, at approximately 10:00 a.m., revealed the consultant recommended using the black rubber handled tablespoon if/when Resident #2 was participating in hand-over-hand feeding. The consultant, however, recommended use of a "normal teaspoon" if/when the resident is fed by</p>	I 229	<p>It took many months for the OT to reassess individual #2 mealtime adaptive equipment as recommended by the SLP, despite many attempts made by the previous QIDP to reach him, and have him to the facility.</p> <p>Individual #2 was reassessed by the OT on 9-20-12</p> <p>Refer to attachment #3a</p> <p>Per OT's recommendations, individual #2 must be fed using the built up handle spoon. The OT notes "If at the time she accepts the spoon, allow self-feeding; if she declines to grasp the utensil at the third trial, staff should feed".</p> <p>The same type of spoon will be used for passing medication as well.</p> <p>All staff were inserviced by the OT on 9-21-12</p> <p>Refer to attachment #3b</p> <p>In the future, the QIDP will ensure that the consultants agree on the recommendations pertaining to the individuals's care. The QIDP will coordinate the services, and monitor the care of the individuals in the facility.</p> <p>The QIDP will ensure that the use of all individuals' adaptive equipment is implemented as prescribed by the professionals; additionally, to prevent the delay in services if the consultant can't be reached after a certain period of time, the agency will seek the services of another consultant.</p>

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I 229	Continued From page 5 staff..."teaspoon (not Tablespoon) ...is smaller and easier to control quantity" of food being presented. On August 29, 2012, at 5:58 p.m., review of the facility's staff in-service training records revealed that on August 8, 2012, the qualified intellectual disabilities professional presented training on residents' adaptive equipment. A signature sheet documented the attendance of both Staff #1 and Staff #6 for the training. Observations made at breakfast on August 26, 2012 and during that evening's medication administration revealed that the training had not been effective.	I 229		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the three residents in the sample. (Resident #2) The finding includes: [483.420(a)(3)] The GHPID failed to ensure Resident #2's right to be free from restraint, as	I 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2012
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW 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) COMPLETE DATE
I 500	<p>Continued From page 6</p> <p>follows:</p> <p>[Cross-refer to Federal Deficiency Report - Citation W268] On August 27, 2012, observation at 8:02 a.m. revealed Resident #2 seated in a wheelchair in the living room, with the seat belt fastened. The resident remained in the wheelchair until 8:50 a.m., when the resident was observed eating breakfast in the dining room. At approximately 9:35 a.m., the facility's program director (Staff #10), program coordinator (Staff #4) and the licensed practical nurse (LPN) coordinator (Staff #8) stated that Resident #2 could walk with staff assistance. Staff were to use a gait belt and the wheelchair was used for traveling long distances in the community or for medical appointments. For the remainder of the survey, the resident was observed to ambulate with staff assistance using her gait belt.</p> <p>On August 29, 2012, interviews with Staff #7 (at 8:38 a.m.) and Staff #2 (at 9:15 a.m.) revealed that Resident #2 was placed in the wheelchair with the seat belt fastened in order to prevent the resident from walking alone when staff were working elsewhere in the facility and unavailable to assist the resident with ambulation. They explained that the resident was at risk of falls and required direct physical assistance from staff when ambulating. Staff #2 indicated that this was not the first time the resident had been placed in the wheelchair to prevent her from ambulating while staff were not present.</p> <p>On August 28, 2012, at 4:30 p.m., review of Resident #2's Individual Support Plan (ISP) dated November 10, 2011, identified the use of a padded gait belt for safety while ambulating as well as the wheelchair to be "used only for extended outings." Facility staff were to</p>	I 500	<p>As per PT's recommendations, individual # 2 must use the wheelchair for extended community outings.</p> <p>Refer to attachment #1</p> <p>On August 27, 2012, the staff placed individual #2 on the wheelchair during breakfast because the armchair was broken over the weekend, and was replaced that day in the afternoon. Individual #2 was placed on the wheelchair without the HRC approval.</p> <p>All staff were inserviced by the QIDP on the PT recommendations on 8-30-12</p> <p>Refer to attachment # 2</p> <p>The QIDP has contacted the PT on 10-11-12 to clarify the use of the gait belt.</p> <p>To promote growth and independence, the PT recommendations will indicate the circumstance in which the gait belt must be used.</p> <p>In the future, the QIDP will ensure that the staff implement the recommendations as prescribed by the consulting professionals, and that all restrictive measures are approved by the agency's HRC prior to their implementation.</p>

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I 500	<p>Continued From page 7</p> <p>"encourage <resident's name> to ambulate to improve... strength and endurance."</p> <p>On August 29, 2012, at 10:20 a.m., review of the facility's Human Rights Committee (HRC) minutes from the past 12 months revealed that on October 10, 2011, the HRC reviewed and approved Resident #2's adaptive equipment, including the padded gait belt and a wheelchair "for long distances." There was no evidence that the practice of placing Resident #2 in a wheelchair and fastening the seat belt to prevent her from ambulating without staff present had been reviewed by the HRC.</p>	I 500	<p>As per PT's recommendations, individual # 2 must use the wheelchair for extended community outings.</p> <p>Refer to attachment #1</p> <p>On August 27, 2012, the staff placed individual #2 on the wheelchair during breakfast because the armchair was broken over the weekend, and was replaced that day in the afternoon. Individual #2 was placed on the wheelchair without the HRC approval.</p> <p>All staff were inserviced by the QIDP on the PT recommendations on 8-30-12</p> <p>Refer to attachment # 2</p> <p>The QIDP has contacted the PT on 10-11-12 to clarify the use of the gait belt.</p> <p>To promote growth and independence, the PT recommendations will indicate the circumstances in which the gait belt must be used.</p> <p>In the future, the QIDP will ensure that the staff implement the recommendations as prescribed by the consulting professionals, and that all restrictive measures are approved by the agency's HRC prior to their implementation.</p>