

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

PRINTED: 02/14/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/04/2014 |
| NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| W 000 | <p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from February 3, 2014 through February 4, 2014. A sample of three clients was selected from a population of two males and three females with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Medication Administration Record - MAR Behavior Support Plan - BSP Milligrams - mg Program Director - PD Residential Coordinator - RC Day Program Staff - DPS Group Home for Individuals with Intellectual Disabilities - GHID Physician's Orders - POS Individual Program Plan - IPP Individual Support Plan - ISP Qualified Intellectual Disabilities Professional - QIDP</p> | W 000 | <p style="text-align: center;">RECEIVED MAY 19 2014 BY:</p> | | |
| W 124 | <p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> | W 124 | | | |

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

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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 124 | <p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and their legal guardian to be informed of the client's medical condition, attendant risks of treatment, and the right to refuse treatment, for one of three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>During the entrance conference on February 3, 2014, at 9:25 a.m., interview with the RC revealed that Client #3's mother operated as the clients designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of his medications.</p> <p>On February 4, 2014, at 9:50 a.m., review of Client #3's medical records revealed the client received sedation for the following medical appointments:</p> <ul style="list-style-type: none"> - On December 5, 2013, Xanax 5 mg was given prior to repeated lab work. - On November 7, 2013, Xanax 5 mg was given prior to lab work. - On September 24, 2013, Xanax 4 mg was given prior to the ophthalmology appointment. - On October 22, 2013, Xanax 4 mg was given prior to the podiatry appointment. <p>Continued review of the corresponding medical records confirmed through the MAR and doctor's</p> | W 124 | <p>It is RCM's policy that consents for the medications used for sedation are obtained from the surrogate decision makers/guardians and also approved by the Human rights Committee prior to each medical appointment. Individual #3's consents for the use of sedations were signed by his mother prior to each medical appointment; however, the facility's nurse could not locate the approved consents. All consents were resubmitted to individual #3's surrogate decision maker for approval on 2-10-14</p> <p>The sedations were presented and approved by the Human Rights committee on 2-18-14</p> <p>Refer to attachments #1a, 1b, 1c, 1d, 1e, 1f. In the future, the facility nurse will ensure that all consents for sedation are approved by the surrogate decision makers prior to the medical appointments. Additionally, all record must be filed and available upon request.</p> <p>It can be noted that the resubmitted consents were brought to individual #3's surrogate decision maker earlier during the month for approval, but she was out of town, and could not be reached.</p> | |

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| W 124 | <p>Continued From page 2</p> <p>orders that the aforementioned sedations were administered prior to the appointments.</p> <p>Interview with the facility's RN and QIDP on February 4, 2014, at approximately 5:00 p.m., revealed that the facility had obtained written consent prior to the administration of each sedation from Client #3's surrogate healthcare decision-maker, however, neither the RN nor the QIDP could produce any written evidence that the mother had given consent for the sedation.</p> <p>On February 4, 2014, at 12:50 p.m., review of Client #3's psychological assessment dated December 2, 2013, confirmed that the client does not evidence the capacity to make decisions on his behalf about treatment/habilitation, ongoing medical care, residential placement and financial matters. The client does not demonstrate the capacity to choose the person he/she desires to make those decisions for him, and cannot execute a durable power of attorney.</p> <p>At the time of the survey, the facility failed to provide evidence that Client #3's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to the client and/or the client's designated surrogate healthcare decision-maker for the use of the aforementioned sedation.</p> | W 124 | <p>Refer to W 124 P 2 of 8 Attachments # 1a, 1b, 1c, 1d, 1e</p> <p>Refer to W 124 P 2 of 8 Attachments # 1a, 1b, 1c, 1d</p> <p>Refer to W 124 P 2 of 8 Attachments # 1a, 1b, 1c, 1d</p> | <p>2-18-14</p> <p>2-18-14</p> <p>2-18-14</p> |
| W 125 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients.</p> | W 125 | | |

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| W 125 | <p>Continued From page 3</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to allow and encourage clients and their legal representatives to exercise their rights regarding a loud bed alarm, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>On February 3, 2014, at 12:55 p.m., DPS was observed to assist Client #2 out of a regular chair using the client's gait belt. Further observations revealed Client #2 used a walker with a right wrist brace attached to it for mobility. Client #2 was then observed to walk to the bathroom while DPS supported the client by holding the gait belt.</p> <p>During the environmental walk-thru on February 4, 2014, at 3:48 p.m., observations revealed there was a gray object mounted on the front of Client #2's bed. The QIDP, who accompanied the surveyor during the walk-thru, revealed that the gray object was a bed alarm used to alert staff when Client #2 attempted to get out of the bed at night. When asked to turn the alarm on, a very loud high pitch sound could be heard throughout the facility. At 3:50 p.m., interview with the QIDP revealed that the bed alarm for Client #2 was used for the client's health and safety due to her unsteady gait. It should be noted that Client #2 shared a room with Client #1.</p> | W 125 | <p>It is RCM's policy that all of the individuals' adaptive equipment are approved by the HRC prior to their use.</p> <p>The consent for the use of the bed alarm was approved by individual #2's surrogate decision maker on 2-10-14</p> <p>Refer to attachment #2</p> <p>The use of the bed alarm for individual #2 was presented and approved by the HRC on 2-18-14</p> <p>Refer to attachment #3</p> <p>Since they are other individuals in the facility, the use of the alarm was presented to the HRC, and was approved on 2-18-14</p> <p>Refer to attachment #4</p> <p>Additionally, the surrogate decision makers and guardian for the rest of the individuals in the home were notified on the use of the alarm in the facility on 2-10-14</p> <p>Refer to attachment # 5</p> <p>In the future, the facility management will ensure that all of the individuals' adaptive equipment are approved by the HRC prior to their use, and that the surrogate decision makers are allowed, or given the opportunity to participate in the decision making.</p> | | |

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| W 125 | <p>Continued From page 4</p> <p>On February 4, 2014, at 4:17 p.m., interview with the facility's PD revealed that she believed that the facility's HRC had approved the use of the bed alarm, but could not recall the date. Further interview with the PD revealed that she would present the use of the bed alarm during the next HRC meeting in February 2014. On February 4, 2014, at approximately 4:20 p.m., review of the HRC minutes from May 2013 through January 2014 revealed that Client #3's bed alarm had not been received.</p> <p>Continued interview with the QIDP at approximately 4:25 p.m. revealed Client #2's mother (surrogate healthcare decision-maker) had been made aware of the purpose of the bed alarm and had agreed to its use. A few minutes later, the QIDP stated however, that there was no written documentation available for review to verify that the client's mother had been involved in the decision making process for the use of Client #2's bed alarm. When asked if the use of Client #2's bed alarm was approved by the HRC for the other residents, as the bed alarm was observed to be very loud, the QIDP stated "she did not believe so".</p> <p>At the time of the survey, there was no evidence that the families and or legally sanctioned representatives of Clients #1, #2, #3, #4 and #5 gave consent for or were allowed to participate in the decision for the use of the bed alarm. In addition, review of the HRC minutes failed to show evidence that the committee approved the use of the bed alarm to ensure the client rights were protected.</p> | W 125 | <p>It is RCM's policy that all of the individuals' adaptive equipment are approved by the HRC prior to their use.</p> <p>The consent for the use of the bed alarm was approved by individual #2's surrogate decision maker on 2-10-14</p> <p>Refer to attachment #2</p> <p>The use of the bed alarm for individual #2 was presented and approved by the HRC on 2-18-14</p> <p>Refer to attachment #3</p> <p>Since they are other individuals in the home, the use of the bed alarm was presented and approved by the HRC on 2-18-14</p> <p>Refer to attachment #4</p> <p>Additionally, the surrogate decision makers and guardian for the rest of the individuals in the home were notified on the use of the alarm in the facility on 2-10-14</p> <p>Refer to attachment # 5</p> <p>In the future, the house management will ensure that all of the individuals' adaptive equipment are approved by the HRC prior to their use, and that the surrogate decision makers are allowed or given the opportunity to participate in the decision making.</p> | | |

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| <p>W 249 W 249</p> | <p>Continued From page 5 483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure each client's communication training program was implemented, for one of the three sampled clients. (Clients #3)</p> <p>The finding includes:</p> <p>On February 3, 2014, from 4:37 p.m. to 7:20 p.m., evening observations revealed Client #3 did not use a voice output communication aid during active treatment. At approximately 4:42 p.m., the surveyor greeted Client #3 as the entered the facility from day program; however, the client did not respond. DSP #2 indicated that Client #3 was not verbal. At 4:47 p.m., DSP #2 assisted Client #3 with ambulating to the bathroom. A few minutes later, Client #3 was assisted from the bathroom to the dining table for a snack. At 4:54 p.m., DSP #2 was observed to tell the client what was served for snack. At 5:55 p.m., Client #3 was assisted to the bathroom to wash his/her hands prior to dinner. Continued observations at 6:01 p.m., revealed Client #3 was observed sitting at the dining table eating dinner. At 7:17</p> | <p>W 249 W 249</p> | <p>All staff were previously inserviced on individual #3's communication goal; however, it seems that the training was not effective.</p> <p>All staff were inserviced on individual #3's communication goal by the QIDP with emphasis on documentation on 2-5-14 Refer to attachment #6.</p> <p>In the future, the facility QIDP will ensure that the individuals communication goals are implemented as recommended by the clinicians.</p> | |
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| W 249 | <p>Continued From page 7</p> <p>eating, drinking and going to the bathroom on February 3, 2014. Continued interview with DSP #2 revealed that he failed to present the device to Client #3 prior to snack/dinner time and while assisting the client to the bathroom.</p> <p>Review of the data collection sheets on February 4, 2014, at approximately 1:15 p.m., revealed that the communication program was not implemented on February 3, 2014. Further review of the data revealed the program was implemented 2 times in January 2014 and 1 time in December 2013. This was verified with the QIDP, who assisted the surveyor with reviewing the data for the aforementioned timeframes.</p> <p>At the time of the survey, the facility failed to implement Client #3's communication training program, as recommended.</p> | W 249 | <p>All staff were previously inserviced on individual #3's communication device; however, it seems as the training was not effective.</p> <p>All staff were reinserviced on individual #3's communication goal by the QIDP with emphasis on documentation on 2-5-14 Refer to attachment #6.</p> <p>In the future, the facility QIDP will ensure that the individuals communication goals are implemented as recommended by the clinicians.</p> | | |

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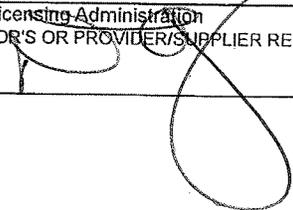
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| 1 000 | <p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from February 3, 2014 through February 4, 2014. A sample of three residents was selected from a population of two males and three females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Medication Administration Record - MAR Behavior Support Plan - BSP Milligrams - mg Program Director - PD Residential Coordinator - RC Day Program Staff - DPS Group Home for Individuals with Intellectual Disabilities - GHIID Physician's Orders - POS Individual Program Plan - IPP Individual Support Plan - ISP Qualified Intellectual Disabilities Professional - QIDP</p> | 1 000 | | |
| 1 090 | <p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to maintain the interior and exterior of the</p> | 1 090 | | |

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| I 090 | <p>Continued From page 1</p> <p>facility in a safe, clean, orderly, attractive, and sanitary manner, for three of the six dining chairs located in the dining room.</p> <p>The finding includes:</p> <p>Observation during the inspection of the environment on February 4, 2014, beginning 3:30 p.m., revealed one dining chair was ripped while exposing the yellow seat cushion. Further observations revealed the other two dining chairs were heavily stained and the seats were sunken in.</p> <p>The QIDP, who was present during the inspection, confirmed the above findings. The QIDP stated she would address the findings with maintenance.</p> | I 090 | <p>All of the dining room chairs were replaced on</p> <p>Refer to attachment # 7</p> <p>In the future, the facility management will ensure that all of the equipment in the home are clean, ordely and attractive.</p> | 2-20-14 |
| I 422 | <p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHIID staff failed to ensure each resident's communication training program was implemented, for one of the three sampled residents. (Residents #3)</p> <p>The finding includes:</p> <p>On February 3, 2014, from 4:37 p.m. to 7:20 p.m., evening observations revealed Resident #3 did not use a voice output communication aid during active treatment. At approximately 4:42 p.m., the surveyor greeted Resident #3 as the</p> | I 422 | | |

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| I 422 | <p>Continued From page 2</p> <p>entered the GHIID from day program; however, the resident did not respond. DSP #2 indicated that Resident #3 was not verbal. At 4:47 p.m., DSP #2 assisted Resident #3 with ambulating to the bathroom. A few minutes later, Resident #3 was assisted from the bathroom to the dining table for a snack. At 4:54 p.m., DSP #2 was observed to tell the resident what was served for snack. At 5:55 p.m., Resident #3 was assisted to the bathroom to wash his/her hands prior to dinner. Continued observations at 6:01 p.m., revealed Resident #3 was observed sitting at the dining table eating dinner. At 7:17 p.m., Resident #3 was assisted back to the bathroom after receiving medications from the nurse.</p> <p>Review of Resident #3's ISP records on February 4, 2014, at 12:35 p.m., revealed an IPP dated January 11, 2014. According to the IPP, "with staff assistance, <resident name> will increase his manual sign language vocabulary by pointing to a picture on a voice output communication aid to enhance his verbal message related to daily living with 80%." Further review of the IPP revealed the following training steps:</p> <ul style="list-style-type: none"> - Staff will place the "Go Talk 4" device with symbols in [resident's name] reach and explain each symbol to the resident (i.e. eat, drink and bathroom). - Using hand over hand assistance, allow [resident name] to touch each symbol as staff explains the meaning to the resident. - [Resident name] will touch to express choice. - Staff will respond to choice. - Staff will mark the data sheet according to the | I 422 | <p>All staff were previously inserviced by the QIDP on the use of individual #3's communication device; however, it seems that the training was not effective.</p> <p>All staff were reinserviced by the facility QIDP on the use of individual #3's communication device with emphasis on the frequency of the data collection on</p> <p>Refer to attachment #6</p> <p>In the future, the facility QIDp will ensure that the individuals' communication device are used as prescribed by the clinicians.</p> <p>2-5-14</p> <p>All staff were previously inserviced by the QIDP on the use of individual #3's communication device; however, it seems that the training was not effective.</p> <p>All staff were reinserviced by the facility QIDP on the use of individual #3's communication device with emphasis on the frequency of the data collection on</p> <p>Refer to attachment #6</p> <p>In the future, the facility QIDp will ensure that the individuals' communication device are used as prescribed by the clinicians.</p> <p>2-5-14</p> |

Health Regulation & Licensing Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0173 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/04/2014 |
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| NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON | STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019 |
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| I 422 | <p>Continued From page 3</p> <p>resident's response.</p> <p>Interview with the QIDP on February 4, 2014, at 1:10 p.m. confirmed that Resident #3 had a "Go Talk 4" communication device that was to be used two days a week (Monday and Wednesday). Further interview revealed that the device should have been presented prior to the resident eating, drinking and going to the bathroom. At approximately 4:50 p.m., interview with DSP #2 also revealed that Resident #3 had a "Go Talk 4" device that should have been presented while the resident was eating, drinking and going to the bathroom on February 3, 2014. Continued interview with DSP #2 revealed that he failed to present the device to Resident #3 prior to snack/dinner time and while assisting the resident to the bathroom.</p> <p>Review of the data collection sheets on February 4, 2014, at approximately 1:15 p.m., revealed that the communication program was not implemented on February 3, 2014. Further review of the data revealed the program was implemented 2 times in January 2014 and 1 time in December 2013. This was verified with the QIDP, who assisted the surveyor with reviewing the data for the aforementioned timeframes.</p> <p>At the time of the survey, the GHIID failed to implement Resident #3's communication training program, as recommended.</p> | I 422 | <p>All staff were previously inserviced by the QIDP on the use of individual #3's communication device; however, it seems that the training was not effective.</p> <p>All staff were reinserviced by the facility QIDP on the use of individual #3's communication device with emphasis on the frequency of the data collection on</p> <p>Refer to attachment #6</p> <p>In the future, the facility QIDp will ensure that the individuals' communication device are used as prescribed by the clinicians.</p> | 2-5-14 |
| I 500 | <p>3523.1 RESIDENT'S RIGHTS</p> <p>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</p> | I 500 | | |

Health Regulation & Licensing Administration

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|--------------------|--|---------------|--|--------------------|
| I 500 | <p>Continued From page 4</p> <p>laws.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record, the GHIID failed to allow and encourage residents and their legal representatives to exercise their rights regarding a loud bed alarm, for five of the five residents residing in the GHIID. (Residents #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>On February 3, 2014, at 12:55 p.m., DPS was observed to assist Resident #2 out of a regular chair using the resident's gait belt. Further observations revealed Resident #2 used a walker with a right wrist brace attached to it for mobility. Resident #2 was then observed to walk to the bathroom while DPS supported the resident by holding the gait belt.</p> <p>During the environmental walk-thru on February 4, 2014, at 3:48 p.m., observations revealed there was a gray object mounted on the front of Resident #2's bed. The QIDP, who accompanied the surveyor during the walk-thru, revealed that the gray object was a bed alarm used to alert staff when Resident #2 attempted to get out of the bed at night. When asked to turn the alarm on, a very loud high pitch sound could be heard throughout the GHIID. At 3:50 p.m., interview with the QIDP revealed that the bed alarm for Resident #2 was used for the resident's health and safety due to her unsteady gait. It should be noted that Resident #2 shared a room with Resident #1.</p> <p>On February 4, 2014, at 4:17 p.m., interview with the GHIID's PD revealed that she believed that</p> | I 500 | <p>It is RCM's policy that all of the individuals' adaptive equipment are approved by the HRC prior to their use.</p> <p>The consent for the use of the bed alarm was approved by individual #2's surrogate decision maker on 2-10-14</p> <p>Refer to attachment #2</p> <p>The use of the bed alarm by individual #2 was presented and approved by the HRC on 2-18-14</p> <p>Refer to attachment #3</p> <p>Since they are other individuals in the the facility the use of the alarm was presented to the HRC and was approved on 2-18-14</p> <p>Refer to attachment #4</p> <p>Additionally the surrogate decision makers and guardian for the rest of the individuals in the home were notified on the use of the alarm in the facility on 2-10-14</p> <p>Refer to attachment # 5</p> <p>In the future, the facility management will ensure that all of the individuals' adaptive equipment are approved by the HRC prior to their use, and also that the surrogate decision makers are allowed or given the opportunity to participate in the decision making.</p> | |

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| I 500 | <p>Continued From page 5</p> <p>the GHIID's HRC had approved the use of the bed alarm, but could not recall the date. Further interview with the PD revealed that she would present the use of the bed alarm during the next HRC meeting in February 2014. On February 4, 2014, at approximately 4:20 p.m., review of the HRC minutes from May 2013 through January 2014 revealed that Resident #3's bed alarm had not been received.</p> <p>Continued interview with the QIDP at approximately 4:25 p.m. revealed Resident #2's mother (surrogate healthcare decision-maker) had been made aware of the purpose of the bed alarm and had agreed to its use. A few minutes later, the QIDP stated however, that there was no written documentation available for review to verify that the resident's mother had been involved in the decision making process for the use of Resident #2's bed alarm. When asked if the use of Resident #2's bed alarm was approved by the HRC for the other residents, as the bed alarm was observed to be very loud, the QIDP stated "she did not believe so".</p> <p>At the time of the survey, there was no evidence that the families and or legally sanctioned representatives of Residents #1, #2, #3, #4 and #5 gave consent for or were allowed to participate in the decision for the use of the bed alarm. In addition, review of the HRC minutes failed to show evidence that the committee approved the use of the bed alarm to ensure the resident rights were protected.</p> | I 500 | <p>It is RCM policy that consents for the medications used for sedation are obtained from the surrogate decision makers/guardians and also approved by the Human rights Committee prior to each medical appointment. Individual #3's consents for the use of sedations were signed by his mother prior to each medical appointment; however, the facility's nurse could not locate the approved consents. All consents were resubmitted to individual #3's surrogate decision maker for approval on 2-10-14</p> <p>The sedations were presented and approved by the Human Rights committee on 2-18-14</p> <p>Refer to attachments #1a, 1b, 1c, 1d, 1e, 1f</p> <p>In the future, the facility nurse will ensure that all consents for sedation are approved by the surrogate decision maker prior to the medical appointments.</p> <p>Additionally, all record must be filed and availbale upon request.</p> <p>It can be noted that the resubmitted consents were brought to individual #3's surrogate decision maker earlier during the month for approval, but she was out of town, and could not be reached.</p> | |

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

Printed: 05/13/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 05/08/2014 |
|--|---|--|--|---|
| NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON | | STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE. NE WASHINGTON, DC 20019 | | |
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| K 000 | INITIAL COMMENTS | K 000 | | |
| K 130 | <p>A Life Safety Code survey was conducted on 5-8-14 of this building to determine with applicable provisions of the 2000 edition of the Life Safety Code. The survey was conducted through observations of the interior and exterior of the building and included the installed sprinkler system, smoke detectors, fire panel, etc., and through interviews with the facility's staff.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>This Standard is not met as evidenced by: 2000 Life Safety Code-LSC 4.6.12.1 Maintenance and Testing (Sprinkler System) Whenever or wherever any device, equipment, system condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this code, such device equipment system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by authority having jurisdiction.</p> <p>Based on observation, the facility sprinkler system one (1) of 1 has not been service for this year.</p> <p>The findings include: Record and review at approximately 12:30pm through 1:15pm on May 8, 2014, that the sprinkler system is due for annual service.</p> <p>Based on observation, the facility tamper one (1) of one is not working on the sprinkler system.</p> <p>The findings include:</p> | K 130 | <p>The annual sprinkler system service was completed on Refer to attachment #1 In the future, the facility's management will ensure that the fire equipment system is continuously maintained.</p> | 5-16-14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Angela Spaulding TITLE Program Director (X6) DATE 5-22-14

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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| NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON | | STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019 | | |
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| K 130 | Continued From page 1 Record and review at approximately 12:30pm through 1:15pm on May 8, 2014, that the sprinkler maintenance report from 2013 stated the tamper is not working. | K 130 | | |
| K0018 | <p>2000 LIFE SAFETY CODE-LSC 4.5.1 Multiple Safeguards The design of every building or structure intended for human occupancy shall be such that reliance for safety to life does not depend solely on any single safeguard. An additional safeguard (s) shall be provided for life safety in case any single safeguard is ineffective due to inappropriate human actions or system failure.</p> <p>Based on observation, the facility dryer lint trap one (1) of one is not clean.</p> <p>The findings include: It was observed at approximately 12:30pm through 1:15pm on May 8, 2014, that the dryer lint trap was not clean out after being used on the main level. Posing as a potential fire hazard.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.6.1 and 33.2.3.5.2.</p> | K0018 | <p>The tamper swith will be rewired by Guardian Fire Protection Services on Refer to attachment #2 In the future, the facility's management will ensure that the fire equipment system is continuously maintained.</p> <p>5-23-14</p> <p>The dryer lint trap was cleaned on In the future, the facility's management will ensure that the dryer lint trap is cleaned after every usage in order to prevent a potential fire hazard.</p> <p>5-8-14</p> | |

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| K0018 | Continued From page 2 | K0018 | | |
| K0147 | <p>This Standard is not met as evidenced by: Based on observation, the facility bedroom closet one (1) of 1 door knob was missing.</p> <p>The findings include: It was observed at approximately 12:30pm through 1:15pm on May 8, 2014, that the northeast bedroom closet door knob is missing from inside of the door. Posing as a potential hazard in an event of an emergency (Abated May 8, 2014)</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility, 32.7.1, 33.7.1</p> | K0147 | <p>The Northeast bedroom closet door knob was replaced on</p> <p>In the future, the facility's management will ensure that all of the closet door knobs are in place in order to prevent a potential hazard in case of an emergency.</p> | 5-9-14 |

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| K0147 | Continued From page 3 <u>This Standard is not met as evidenced by:</u> Based on observation, the facility staff is not familiarize with the fire protection devices in the facility. The findings include: Surveyor's record and review at approximately 12:30pm through 1:15pm on May 8, 2014, that the facility staff need training to familiarize themselves with the fire protection devices used in a event of an emergency. | K0147 | | |
| K0152 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action; and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. | K0152 | All staff were inservice on the fire protection devices by the facility's Program Coordinator on 5-14-14 Refer to attachment # 3 In the future, the facility's management will ensure that the staff are familiar with the fire protection devices used in an event of an emergency | |

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| K0152 | Continued From page 4 | K0152 | | |
| | <p>This Standard is not met as evidenced by: Based on observation, the facility fire drill forms are incomplete.</p> <p>The findings include:</p> <p>Surveyor's record and review at approximately 12:30pm through 1:15pm on May 8, 2014, that the facility staff is not filling out the fire drill forms completely when performing drills.</p> | | <p>All staff were inservice on the appropriate completion of the fire drill forms by the facility's Program Coordinator on 5-14-14 Refer to attachment # 4 In the future, the facility's management will ensure that the staff completely fill fire drill forms when performing the drills.</p> | |