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

PRINTED: 11/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G236	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2620 24TH STREET, NE WASHINGTON, DC 20018

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W 000	INITIAL COMMENTS A recertification survey was conducted from November 5, 2013 through November 8, 2013. A sample of three clients was selected from a population of five individuals with profound intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations, interviews, and with direct support staff, nursing and administrative staff, as well as a review of records, including incident reports. Note: The below are abbreviations that may appear throughout the body of this report. Program Director (PD) Direct Support Professional (DSP) Licensed Practical Nurse (LPN) Day Program Staff (DPS) Individualized Program Plan (IPP) House Manager (HM) Gastrointestinal (GI)	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that outside services utilized each client's adaptive equipment (communication device) and also failed to inform a visually impaired client of the contents of their lunch prior to serving it, for two of three clients in	W 120		

Received 12/6/13
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: Angele Ekawa — TITLE: Program Director — (X6) DATE: 12-6-13

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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 120	Continued From page 1 the sample. (Clients #1 and #3) The findings include: 1. The day program failed to ensure that Client #1, who was visually impaired, was informed of what she was having for lunch. During the entrance conference on November 5, 2013, at approximately 3:00 p.m., the HM revealed that Client #1 was blind. At 5:30 p.m., Client #1 sat at the dining room table, then DSP #1 informed the client what was being served for dinner. On November 6, 2013, beginning at 11:45 a.m., DPS #2 was observed to place Client #1's lunch in front of her. Client #1 then began to feed herself. DPS #2 was not observed to inform the client of what she was being served for lunch. Interview with DPS #2 on November 6, 2013, at approximately 12:15 p.m., revealed that she on occasion will tell Client #1 what she was having for lunch and other times the client "feels for it". At the time of survey, DPS #2 failed to inform Client #1 of her lunch. 2. The day program failed to ensure Client #3's communication program was implemented as recommended. On November 6, 2013, beginning at 12:35 p.m., Client #3 was observed at her day program. Upon entering her classroom, DPS #1 asked the client, "do you know the surveyor." In response, the client made eye contact with the surveyor. DPS #1 then placed a circular plastic object in the	W 120	1. It is the DSPs routine practice that individual #1 be informed on what is being served for her meals. The staff describes the contents of the plates, the orientation of the foods on the plates, as well as the type of beverages that have been presented and served. The day program did not inform individual #1 of the foods and beverages being served during lunch on November 5, 2013. The Program Director reported to individual #1 day program to inservice the staff on 12-5-13 Refer to attachment #1 In the future, the facility QIDP will ensure that the day program informs individual#1 on the contents of her plate during mealtime;additionally, the QIPD will make unannounced visits at the day program during lunch time to ensure that the practice is being implemented.	

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W 120	Continued From page 2 client's hand. The client screamed and dropped the item. DPS #1 placed it back in her hand and asked, "Can you hold it for five minutes for me?" The client responded by looking at staff and by vocalizing unintelligibly. At approximately 12:40 p.m., Client #3 began to vocalize different sounds. At 12:51 p.m., the surveyor asked, does the client utilize a communication device? DPS #1 retrieved it out of the client's bag and said "she uses it sometimes." (It should be noted on November 5, 2013 at 6:44 p.m., a Go-talk communication device was observed in the client's bedroom). Review of Client #3's IPP dated October 8, 2013 on November 8, 2013, at 9:30 a.m., revealed the following communication program objective: "Given hand over hand assistance, [Client #3] will utilize a low tech communication device to express basic fundamental wants and needs with 80% accuracy of recorded trials per month for three consecutive months by September 2014." Continued review of the IPP revealed the following program implementation strategies: a. After the staff ask the client a yes question and has modeled pressing the yes cell, the client will press the yes cell. b. After the staff ask the client a no question and has modeled pressing the no cell, the client will press the no cell. Interview with the HM on November 7, 2013, at approximately 3:00 p.m. revealed that the client was required to use the communication device at the day program to communicate her needs. On November 6, 2013, interview with DPS #1 at	W 120	2. Individual #3 has a program goal that consists of the use of a communication assistive device "Low Tech device Go Talk 4) that she must use at the residence as well at the day program to express her basic fundamental wants and needs. Individual #3' communication device is brought to the day program by her staff on a daily basis to ensure the continuation of the active treatment. On November 5, 2013, the day program did not fully provide individual #3 with the full implementation of the communication goal. The day program staff was inserviced by the Program Director on the implementation of the communication goal on 12-4-13 Refer to attachment #2 In the future, the facility QIDP will ensure that the individuals' communication devices are fully used at the	

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W 120	Continued From page 3 12:54 p.m., revealed that Client #3 was not encouraged to use her communication device as needed.	W 120	facility and day program as recommended by the Speech and Language Pathologist.	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify guardians of all emergency room visits, for two of the five clients residing in the facility. (Clients #2 and #5) The finding includes: On November 6, 2013, beginning at 9:00 a.m., review of incident reports revealed that on September 20, 2013, Client #5 was taken to the emergency room after she began coughing up blood. Further review of the incident report revealed no evidence that Client #5's guardian and/or family members had been notified of the incident. Continued review of the facility incident reports revealed that on October 23, 2013, Client #2 was taken to the emergency room after having a seizure that lasted more than three minutes. Further review of the incident report revealed no evidence that Client #2's guardian and/or family members had been notified of the incident.	W 148	It is RCM policy that all of the appropriate entities including guardians and family members are notified of the individuals incidents including the ER visits. Individual #2 has a guardian and individual #5 has a family member. The facility QIDP who covered the house during the periods where these incidents occurred is no longer employed by RCM, and consequently can't be inserviced on the incident management; however, the Program Director has inserviced the new QIDP on the incident management policy during the house inservice on 11-22-13 Refer to attachment #3 In the future, the facility will ensure that all incidents are notified to the family members and guardians.	

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W 148	Continued From page 4 During the entrance conference on November 5, 2013, at approximately 3:00 p.m., revealed that both clients had legal guardians. Interview with the PD on November 6, 2013, at approximately 3:00 p.m., revealed that she did not know if either Client #2 or Client #5's guardians were made aware of the aforementioned incidents. At the time of the survey, the facility failed to provide evidence that legal guardians were made aware of the incidents identified above.	W 148		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a client with training to reduce the client ' s dependency on the use of a bib during mealtimes for one of the three clients in the sample. (Client #1) The finding includes: On November 7, 2013, at 3:05 p.m., Client #1, who was assisted during meals, observed wearing a bib while eating yogurt and drinking water. No spills were noted on the bib after the client had completed 100% of the yogurt and	W 242		

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W 242	Continued From page 5 water. On November 7, 2013, at 4:02 p.m., interview with the PD revealed that Client #1 had been wearing bibs during mealtimes for the protection of the client's clothing. When asked if there was an attempt to teach the client to protect the client's clothing during mealtimes, the PD did not answer the question; however, she acknowledged that a formal recommendation was not considered for Client #1 to learn how to protect her clothing or to use a napkin. At the time of the survey, the facility failed to provide evidence that Client #1 was given an opportunity to learn how to protect her clothing during mealtimes without the use of a bib.	W 242	All staff were inserviced on individual#1's adaptive equipment by the facility Program Coordinator on 11-22-13 A goal has been developed to assist individual #1 to clean her mouth with a paper towel to protect her clothing without the use of the bib. Refer to attach #4 and 4.1 In the future, the facility management will ensure that the individuals use only the adaptive equipment prescribed by the clinicians.	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. 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 consistently, for one of the three clients in the sample. (Client #3) The finding includes:	W 249		

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W 249	Continued From page 6 On November 5, 2013, at 6:44 p.m., Client #3's communication device was observed in her bedroom. At 8:08 p.m., the house manager escorted the client, who used a wheelchair for mobility, to the living room to watch television. The house manager asked, "What do you want to watch?" Review of Client #3's IPP dated October 8, 2013 on November 8, 2013, at 9:30 a.m., revealed the following communication program objective: "Given hand over hand assistance, [Client #3] will utilize a low tech communication device to express basic fundamental wants and needs with 80% accuracy of recorded trials per month for three consecutive months by September 2014." Interview with the HM on November 7, 2013, at approximately 3:00 p.m. revealed that the client was required to use the communication device daily to communicate her needs. On November 8, 2013, at approximately 4:30 p.m., DSP #1 revealed that Client #3 was required to use her communication device daily. At no time during the survey period was Client #3 observed with her communication device.	W 249	Individual #3 has a low tech communication device that she needs to use to express her basic fundamental wants and needs. All staff were inserviced on individual #3's functional communication goal by the Program Director on 11-22-13 Refer to attachment #5 In the future, the house management will ensure that the individuals' communication goals are implemented as recommended by the Speech and Language Pathologist.	
W 331	483.460(c) NURSING SERVICES 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 review, the facility failed to ensure that a recommendation for a colonoscopy and	W 331		

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W 331	Continued From page 7 orthopedic shoes were addressed for two of the three clients in the sample. (Client #1 and #2) The finding includes: 1. Record review on November 6, 2013, beginning at 9:30 a.m., revealed Client #2 was admitted to the hospital for a gastrointestinal bleed. Review of the hospital's discharge form dated May 25, 2013, revealed "the patient should have a colonoscopy done in the near future." Further review of the record failed to disclose that the primary care provider was made aware of the recommendations. Interview with LPN #1 on November 8, 2013, at approximately 12:15 p.m., revealed that the client did not need a colonoscopy. The LPN then presented for review a GI consultation form dated February 1, 2012. The form, which was completed 15 months prior to the hospital's discharge recommendation, revealed that a colonoscopy was not warranted. The nurse was queried to ascertain how the May 25, 2013 recommendation for the colonoscopy was addressed. The LPN continued to indicate that the colonoscopy was not needed. At the time of the survey, the nurse failed to provide evidence to ensure Client #2's May 25, 2013, recommendation for a colonoscopy was addressed by the primary care physician. 2. Observation of the medication administration record on November 5, 2013, at 7:35 p.m., revealed Client #1 received Glipizide and Metformin for diabetes. On November 8, 2013 at 5:03 p.m., interview with LPN #1 revealed Client #1 was recommended	W 331	1.Individual #2 has a colonoscopy completed on February 1, 2012 and the recommendation was to have another colonoscopy in 5 years. Individual # 2 was hospitalized, and was discharged in May 5-22-13 with the recommendation to have another colonoscopy in the near future; however, the facility's nurse failed to notify the PCP because of the 5 years recommendation. The facility's nurse informed the PCP, and she noted that individual#2 is not due for another colonoscopy at this time Refer to attachment #6 In the future, the facility nursing management will ensure that the PCP is informed on all of the recommendations from the clinicians. 2. Individual#1 has a pair of orthopaedic shoes in the house that she does not wear because they do not fit.	12-4-13

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W 331	Continued From page 8 for orthopedic shoes secondary to her diabetes in February of 2013. When asked to verify that Client #1 had a pair of orthopedic shoes as recommended by her podiatrist, LPN # 1 revealed that the shoes were returned because they did not fit. Continued interview revealed that Client #1 never received a replacement pair of orthopedic shoes as recommended, and LPN #1 was not aware when Client #1 would receive a new pair. On November 8, 2013, at 8:54 a.m., review of the medical record revealed a podiatry consult dated August 8, 2013. The consult revealed that Client #1 's podiatrist continued to request orthopedic shoes due to Client #1's diabetes. At the time of the survey, there was no evidence that the nurse ensured that Client #1 received her orthopedic shoes as recommended by the podiatrist	W 331	Individual #1 has those shoes when she joined the new provider;many attends made to find the origin of the shoes, and the Podiatrist who prescribed them have failed. Individual#1 had a podiatry appointment on 5-9-13, and Podiatrist did not prescribe the shoes despite the request by the nurse. Another appointment was scheduled on 11-4-13, the podiatrist failed to provide a prescription. Another Podiatrist was located, and Individual #1 has an appointment on 12-11-13 Refer to attachment #7 In the future, the provider will ensure that the individuals adaptive equipment are obtained in a reasonable time as stipulated in the adaptive equipment policy.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to ensure that each client received recommended adaptive equipment, for three of three clients in the sample. (Clients #1 #2 and #3) The findings include:	W 436		

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W 436	Continued From page 9 1. Observation of the medication administration record on November 5, 2013, at 7:35 p.m., revealed Client #1 received Glipizide and Metformin for diabetes. On November 8, 2013 at 5:03 p.m., interview with LPN #1 revealed Client #1 was recommended for orthopedic shoes secondary to her diabetes in February of 2013. When asked to verify that Client #1 had a pair of orthopedic shoes as recommended by her podiatrist, LPN # 1 revealed that the shoes were returned because they did not fit. Continued interview revealed that Client #1 never received a replacement pair of orthopedic shoes as recommended, and LPN #1 was not aware when Client #1 would receive a new pair. On November 8, 2013, at 8:54 a.m., review of the medical record revealed a podiatry consult dated August 8, 2013. The consult revealed that Client #1 's podiatrist continued to request orthopedic shoes due to Client #1's diabetes. At the time of the survey, there was no evidence that the facility ensured that Client #1 received her orthopedic shoes as recommended by the podiatrist. 2. On November 5, 2013, at 5:10 p.m., Client #2 was observed in her wheelchair as she was escorted to the living room. The wheelchair handle was wrapped with duct tape. According to Client #2's habilitation records on November 6, 2013, beginning at 11:04 a.m., the PT assessment dated July 10, 2013, recommended a new custom wheelchair. Review of the client's records revealed an requisition for a new wheelchair, dated September 11, 2013, revealed a request to replace Client #2's wheelchair.	W 436	1. Refer to W 331 PP 8 & 9 Refer to attachment #7 2. It is RCM policy that the adaptive equipment are obtained on a reasonable basis. Individual #2's wheelchair acquisition was delayed because the annual PT assessment was obtained late. The measurements for individual #2's custom wheelchair was completed on 11-6-13. The second fitting was completed on 12-4-13 In the future, the facility will ensure that the individuals'	12-4-13

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W 436	Continued From page 10 Interview with the house manager on November 7, 2013, at approximately 2:00 p.m., revealed that she was not sure why the requisition for Client #2's wheelchair was made two months after the recommendation. At the time of survey, the facility failed to request a new custom wheelchair timely for Client #2 as recommended by the physical therapist. 3. On November 6, 2013, beginning at 12:35 p.m., Client #3 was observed at her day program. Upon entering her classroom, DPS #1 asked the client, "do you know the surveyor." In response, the client made eye contact with the surveyor. DPS #1 then placed a circular plastic object in the client's hand. The client screamed and dropped the item. DPS #1 placed it back in her hand and asked, "Can you hold it for five minutes for me?" The client responded by looking at staff and by vocalizing unintelligibly. At approximately 12:40 p.m., Client #3 began to vocalize different sounds. At 12:51 p.m., the surveyor asked, does the client utilize a communication device? DPS #1 retrieved it out of the client's bag and said "she uses it sometimes." (It should be noted on November 5, 2013 at 6:44 p.m., a Go-talk communication device was observed in the client's bedroom). DPS #1 then placed the communication device in front of the client and began to push the buttons. When DSP #1 pressed the buttons, the picture buttons failed to operate, however the yes and no buttons were operable. When asked, DPS #1 stated that the picture buttons have not been working for a week. On November 8, 2013, interview with the house manger at 2:30 p.m., revealed she was unaware that the client's communication device was not	W 436	adaptive equipment are on a timely manner as stipulated on the adaptive equipment policy. 3.Individual #3 has a program goal that consists of the use of a communication assistive device "Low Tech device Go Talk 4) that she must use at the residence as well at the day program to express her basic fundamental wants and needs. Individual #3' communication device is brought to the day program by her staff on a daily basis to ensure the continuation of the active treatment. On November 5, 2013, the day program did not provide individual #3 with the full implementation of the communication goal. The day program's staff was inserviced by the Program Director on the implementation	

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W 436	Continued From page 11 working.	W 436	of the goal on Refer to attachment #2 In the future, the facility QIDP will ensure that the individual #3's communication device is fully used at the facility and day program as recommended the Speech and Language Pathologist.	12-4-13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0267	A. BUILDING: _____ B. WING _____	11/08/2013

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I 000	INITIAL COMMENTS A licensure survey was conducted from November 5, 2013 through November 8, 2013. A sample of three residents was selected from a population of five individuals with profound intellectual disabilities. The findings of the survey were based on observations, interviews, and with direct support staff, nursing and administrative staff, as well as a review of records, including incident reports. Note: The below are abbreviations that may appear throughout the body of this report. Program Director (PD) Direct Support Professional (DSP) Licensed Practical Nurse (LPN) Day Program Staff (DPS) Individualized Program Plan (IPP) House Manager (HM) Gastrointestinal (GI)	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 individuals with intellectual disabilities (GHIID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for four of four residents residing in	I 090		

Health Regulation & Licensing Administration

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I 090	Continued From page 1 the facility. (Residents #1, #2, #3 #4 and #5) The findings include: Observation during Inspection of the environment on November 8, 2013, beginning at 4:45 p.m., revealed the following: 1. Resident #4's pillow and comforter were stained. There was also no pillow case on the pillow. 2. There was no cover on Resident #1's toothbrush. 3. Resident #1's dresser drawer was off track, creating a potential safety hazard. 4. Resident #2's dresser drawer was missing a handle. 5. The covering of the shower gurney was observed to be worn and torn. The house manager who was present during the inspection, confirmed the above findings. The house manager stated she would address the findings.	I 090	1. Individual#4's pillow and comforter were replaced on 11-30-13 2. Individual's #1 toothbrush cover was replaced on 11-08-13 3. Individual #1's dresser drawer was repaired on 12-3-13 4. The handle missing on individual #4's dresser drawer was replaced on 12-3-13 5. The covering of the shower gurney was ordered, and will be replaced on 12-9-13 In the future, the facility management will ensure that all of the equipment in the facility are in a working condition.	
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.	I 374		

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I 374	Continued From page 2 This Statute is not met as evidenced by: Based on staff interview and record review, the GHIIP failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for two of the five residents included in the sample. (Residents #2 and #5) The findings include: On November 6, 2013, beginning at 9:00 a.m., review of incident reports revealed that on September 20, 2013, Resident #5 was taken to the emergency room after she began coughing up blood. Further review of the incident report revealed no evidence that Resident #5's guardian and/or family members had been notified of the incident. Continued review of the facility incident reports revealed that on October 23, 2013, Resident #2 was taken to the emergency room after having a seizure that lasted more than three minutes. Further review of the incident report revealed no evidence that Resident #2's guardian and/or family members had been notified of the incident. During the entrance conference on November 5, 2013, at approximately 3:00 p.m., revealed that both residents had legal guardians. Interview with the PD on November 6, 2013, at approximately 3:00 p.m., revealed that she did not know if either Resident #2 or Resident #5's guardians were made aware of the aforementioned incidents. At the time of the survey, the facility failed to provide evidence that legal guardians were made aware of the incidents identified above.	I 374	It is RCM policy that all of the appropriate entities including guardians and family members are notified of the individuals incidents including the ER visits. Individual #2 has a guardian and individual #5 has a family member. The facility QIDP who covered the house during the periods where these incidents occurred is no longer employed by RCM, and consequently can't be inserviced on the incident management;however, the Program Director did inservice the new QIDP during the house inservice on 11-22-13 Refer to attachment # 3 In the future, the facility will ensure that all incidents are notified to the family members and to the guardians.	

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I 379	Continued From page 3	I 379		
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 review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for two of five residents of the facility. (Residents #2 and #5) The findings include: On November 6, 2013, beginning at 9:00 a.m., review of incident reports revealed that on September 20, 2013, Resident #5 was taken to the emergency room after she began coughing up blood. Further review of the incident report revealed no evidence that Resident #5's guardian and/or family members had been notified of the incident. Continued review of the facility incident reports revealed that on October 23, 2013, Resident #2	I 379	Refer to W 148 P. 4 of 12 11 22-13 Refer to attachment #3	

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I 379	Continued From page 4 was taken to the emergency room after having a seizure that lasted more than three minutes. Further review of the incident report revealed no evidence that Resident #2's guardian and/or family members had been notified of the incident. During the entrance conference on November 5, 2013, at approximately 3:00 p.m., revealed that both residents had legal guardians. Interview with the PD on November 6, 2013, at approximately 3:00 p.m., revealed that she did not know if either Resident #2 or Resident #5's guardians were made aware of the aforementioned incidents. At the time of the survey, the facility failed to provide evidence that legal guardians were made aware of the incidents identified above.	I 379	Refer to W 148 P. 4 of 12 11 22-13 Refer to attachment #3 Refer to W 148 P. 4 of 12 11 22-13 Refer to attachment #3	
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 observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) nursing services failed to ensure that a recommendation for a colonoscopy and orthopedic shoes were addressed for two of the three Residents in the sample. (Resident #1 and #2) The findings include:	I 401		

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I 401	Continued From page 5 1. Record review on November 6, 2013, beginning at 9:30 a.m., revealed Resident #2 was admitted to the hospital for a gastrointestinal bleed. Review of the hospital's discharge form dated May 25, 2013, revealed "the patient should have a colonoscopy done in the near future." Further review of the record failed to disclose that the primary care provider was made aware of the recommendations. Interview with LPN #1 on November 8, 2013, at approximately 12:15 p.m., revealed that the Resident did not need a colonoscopy. The LPN then presented for review a GI consultation form dated February 1, 2012. The form, which was completed 15 months prior to the hospital's discharge recommendation, revealed that a colonoscopy was not warranted. The nurse was queried to ascertain how the May 25, 2013 recommendation for the colonoscopy was addressed. The LPN continued to indicate that the colonoscopy was not needed. At the time of the survey, the nurse failed to provide evidence to ensure Resident #2's May 25, 2013, recommendation for a colonoscopy was addressed by the primary care physician. 2. Observation of the medication administration record on November 5, 2013, at 7:35 p.m., revealed Resident #1 received Glipizide and Metformin for diabetes. On November 8, 2013 at 5:03 p.m., interview with LPN #1 revealed Resident #1 was recommended for orthopedic shoes secondary to her diabetes in February of 2013. When asked to verify that Resident #1 had a pair of orthopedic shoes as recommended by her podiatrist, LPN # 1 revealed that the shoes were returned because they did not fit. Continued interview revealed that Resident	I 401	1.Refer to W 331 PP 7 & 8 of 12 Refer to attachment #6 1.Refer to W 331 PP 7 & 8 of 12 Refer to attachment #6 1.Refer to W 331 PP 7 & 8 of 12 Refer to attachment #6 2.Refer to W 331 PP 8 & 9 Refer to attachment #7	12-4-13 12-4-13 12-4-13 12-4-13

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I 401	Continued From page 6 #1 never received a replacement pair of orthopedic shoes as recommended, and LPN #1 was not aware when Resident #1 would receive a new pair. On November 8, 2013, at 8:54 a.m., review of the medical record revealed a podiatry consult dated August 8, 2013. The consult revealed that Resident #1 's podiatrist continued to request orthopedic shoes due to Resident #1's diabetes. At the time of the survey, there was no evidence that the nurse ensured that Resident #1 received her orthopedic shoes as recommended by the podiatrist	I 401	1.Refer to W 331 PP 8 & 9 Refer to attachment #7	12-4-13
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure its outside day program met the needs of each resident, for two of three residents in the sample. (Resident #3) (Residents #1 and #2) The findings include: 1. The day program failed to ensure that Resident #1, who was visually impaired, was informed of what she was having for lunch.	I 405		

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I 405	Continued From page 7 During the entrance conference on November 5, 2013, at approximately 3:00 p.m., the HM revealed that Resident #1 was blind. At 5:30 p.m., Resident #1 sat at the dining room table, then DSP #1 informed the resident what was being served for dinner. On November 6, 2013, beginning at 11:45 a.m., DPS #2 was observed to place Resident #1's lunch in front of her. Resident #1 then began to feed herself. DPS #2 was not observed to inform the resident of what she was being served for lunch. Interview with DPS #2 on November 6, 2013, at approximately 12:15 p.m., revealed that she on occasion will tell Resident #1 what she was having for lunch and other times the resident "feels for it". At the time of survey, DPS #2 failed to inform Resident #1 of her lunch. 2. The day program failed to ensure Resident #3's communication program was implemented as recommended. On November 6, 2013, beginning at 12:35 p.m., Resident #3 was observed at her day program. Upon entering her classroom, DPS #1 asked the resident, "do you know the surveyor." In response, the resident made eye contact with the surveyor. DPS #1 then placed a circular plastic object in the resident's hand. The resident screamed and dropped the item. DPS #1 placed it back in her hand and asked, "Can you hold it for five minutes for me?" The resident responded by looking at staff and by vocalizing unintelligibly. At approximately 12:40 p.m., Resident #3 began to vocalize different sounds. At 12:51 p.m., the	I 405	1.Refer to W 120 P 2 of 12 Refer to attachment 1 1.Refer to W 120 P 2 of 12 Refer to attachment 1 1. Refer to W 120 P 2 of 12 Refer to attachment 1 2.Individual #3 has a program goal that consists of the use of a communication assistive device "Low Tech device Go Talk 4) that she must use at the residence as well at the day program to express her basic fundamental wants and needs. Individual #3' communication device is brought to the day program by her staff on a daily basis to ensure the continuation of the active treatment.	12-5-13 12-5-13 12-5-13

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I 405	Continued From page 8 surveyor asked, does the resident utilize a communication device? DPS #1 retrieved it out of the resident's bag and said "she uses it sometimes." (It should be noted on November 5, 2013 at 6:44 p.m., a Go-talk communication device was observed in the resident's bedroom). Review of Resident #3's IPP dated October 8, 2013 on November 8, 2013, at 9:30 a.m., revealed the following communication program objective: "Given hand over hand assistance, [Resident #3] will utilize a low tech communication device to express basic fundamental wants and needs with 80% accuracy of recorded trials per month for three consecutive months by September 2014." Continued review of the IPP revealed the following program implementation strategies: a. After the staff ask the resident a yes question and has modeled pressing the yes cell, the resident will press the yes cell. b. After the staff ask the resident a no question and has modeled pressing the no cell, the resident will press the no cell. Interview with the HM on November 7, 2013, at approximately 3:00 p.m. revealed that the resident was required to use the communication device at the day program to communicate her needs. On November 6, 2013, interview with DPS #1 at 12:54 p.m., revealed that Resident #3 was not encouraged to use her communication device as needed.	I 405	On November 5, 2013, the day program did not provide individual #3 with the full implementation of the communication goal. The day program staff was inserviced by the Program Director on the implementation of the communication goal on 12-4-13 Refer to attachment #2 In the future, the facility QIDP will ensure that the individuals' communication devices are fully used at the facility as well as at the day program.	
I 420	3521.1 HABILITATION AND TRAINING	I 420		

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I 420	Continued From page 9 Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide a resident with training to reduce the resident ' s dependency on the use of a bib during mealtimes for one of the three residents in the sample. (Resident #1) The finding includes: On November 7, 2013, at 3:05 p.m., Resident #1, who was assisted during meals, observed wearing a bib while eating yogurt and drinking water. No spills were noted on the bib after the resident had completed 100% of the yogurt and water. On November 7, 2013, at 4:02 p.m., interview with the PD revealed that Resident #1 had been wearing bibs during mealtimes for the protection of the resident's clothing. When asked if there was an attempt to teach the resident to protect the resident's clothing during mealtimes, the PD did not answer the question; however, she acknowledged that a formal recommendation was not considered for Resident #1 to learn how to protect her clothing or to use a napkin. At the time of the survey, the facility failed to provide evidence that Resident #1 was given an opportunity to learn how to protect her clothing during mealtimes without the use of a bib.	I 420	All staff were inserviced on individual#1's adaptive equipment by the facility Program Coordinator on 11-22-13 A goal has been developed to assist individual #1 to clean her mouth with a paper towel to protect her clothing without the use of the bib. Refer to attach #4 & 4.1 In the future, the facility management will ensure that the individuals use only the adaptive equipment prescribed by the clinicians.	

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I 422	Continued From page 10	I 422		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for individuals with intellectual disabilities (GHIID) staff failed to ensure each resident's communication training programs were implemented consistently, for one of the three residents in the sample. (Resident #3) The finding includes: On November 5, 2013, at 6:44 p.m., Resident #3's communication device was observed in her bedroom. At 8:08 p.m., the house manager escorted the resident, who used a wheelchair for mobility, to the living room to watch television. The house manager asked, "What do you want to watch?" Review of Resident #3's IPP dated October 8, 2013 on November 8, 2013, at 9:30 a.m., revealed the following communication program objective: "Given hand over hand assistance, [Resident #3] will utilize a low tech communication device to express basic fundamental wants and needs with 80% accuracy of recorded trials per month for three consecutive months by September 2014." Interview with the HM on November 7, 2013, at approximately 3:00 p.m. revealed that the resident was required to use the communication device daily to communicate her needs. On	I 422	Individual #3 has a low tech communication device that she needs to use to express her basic fundamental wants and needs. All staff were inserviced on individual #3's functional communication goal by the program Director on 11-22-13 Refer to attachment #5 In the future, the house management will ensure that the individuals' communication goals are implemented as recommended by the Speech and Language Pathologist.	

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	HFD03-0267	A. BUILDING: _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2620 24TH STREET, NE WASHINGTON, DC 20018

(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 422	Continued From page 11 November 8, 2013, at approximately 4:30 p.m., DSP #1 revealed that Resident #3 was required to use her communication device daily. At no time during the survey period was Resident #3 observed with her communication device.	I 422		