

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/13/2013
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NAME OF PROVIDER OR SUPPLIER  RCM OF WASHINGTON, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET SE WASHINGTON, DC 20032
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from December 11, 2013, through December 13, 2013. A sample of three clients was selected from a population of six individuals with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations, interviews, and the review of records, including incident reports.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Clinical Director (CD) Chief Operating Officer (COO) Director of Nursing (DON) Direct Support Professional (DSP) Group Home for Individuals with Intellectual Disabilities (GHIID) Intermediate Care Facility (ICF) Incident Management Coordinator (IMC) Individual Support Plan (ISP) Individualized Program Plan (IPP) Licensed Practical Nurse (LPN) Physical Therapist (PT) Qualified Intellectual Disabilities Professional (QIDP) Registered Nurse (RN) Emergency Room (ER) Facility Coordinator (FC)</p>	W 000	<p>Received 1/6/14</p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p>	W 369		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Glenn Joseph, Director of Community Living</i>	TITLE Director of Community Living	(X6) DATE 1-6-14
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A 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 369 Continued From page 1

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 one of six clients residing in the facility. (Client #6)

The finding includes:

During the medication administration on December 11, 2013, beginning at 8:05 p.m., Client #6 was observed to receive the following medications by mouth: Levetiracetam 750 milligrams (mgs.), 2 tablets (1500 mgs. ), Simvastatin 20 mg, 1 tablet, Docusate 100 mg tablet, Calcium 600/400 tablet, Sodium Bicarbonate, 650 mg. tablet, Topiramate 100 mg tablet, Topiramate 200 mg tablet, and Primadone 250 mg tablet.

On December 11, 2013, at 8:22 p.m., interview with LPN #1 revealed that Client #6 was also prescribed to receive Lunigan Ophthalmic Solution, one drop to each eye daily in the evening for glaucoma. After searching the medication supply for the eye drops, at 8:25 p.m., LPN #1 stated that the eye drops were not available. LPN #1 further stated that she would follow-up with the pharmacy on the next morning.

On December 11, 2013, at 8:27 p.m., review of the medication administration record (MAR) and the corresponding physician's orders dated December 1, 2013, confirmed that Client #6 was prescribed to be administered Lunigan Ophthalmic Solution 0.01% eye drops, one drop in each eye in the evening every day.

At the time of the survey, the facility failed to

W 369

On the morning of December 11, 2013 the LPN identified that the cited medication for this individual had expired on that day and a re-order was requested from the pharmacy; however, the medication did not arrive to the facility in time for the evening medication pass. The medication was picked up by the LPN from the pharmacy on the morning of 12-12-13 and this individual was administered his evening dosage. An incident report was filed due to the medication error. In the future all nursing professionals will review all medications for the upcoming month by the end of each proceeding month in order to identify any issues surrounding running out of medication mid-month. All medication running the risk of expiring or running out mid-month will be ordered in advance at the beginning of the month to avoid a repeat of this nature.

12-12-13

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W 369	Continued From page 2 ensure that all drugs were administered without error.	W 369		
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 observation, interview and record review, the facility failed to ensure that recommended adaptive equipment was maintained in good repair for one of three clients in the sample. (Client #3)  The findings includes:  The facility failed to ensure the seat cushion of Client #3's wheelchair was maintained in good repair, as evidenced below:  On December 13, 2013, at 8:52 a.m., Staff #1 requested Client #3 to stand up from the wheelchair in which he was sitting. At that time, the wheelchair seat cushion was observed to be torn across the front edge. At 9:00 a.m., Staff #1 and LPN #1 repeatedly encouraged the client to stand up from his wheelchair and offered him assistance to walk from the room to the van located in the yard. After Client #3 stated, "No, no, no," and refused to walk from the room, he was then allowed to sit in his wheelchair and was transported to the van.	W 436		

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W 436	<p>Continued From page 3</p> <p>On December 13, 2013, at 9:20 a.m., interview with Staff #1 and LPN #1 revealed Client uses his wheelchair for distance travel, at his day program, and whenever he refuses to, or is unable to walk. Although, the aforementioned staff acknowledged that the seat cushion cover was torn, they were not able to verify how long the seat cushion had been torn. Interview with the agency's COO on December 13, 2013, at 12:17 p.m., revealed staff had not reported that Client #3's seat cushion was torn.</p> <p>On December 13, 2013, at 9:18 a.m., review of Client #3's physician orders dated December 1, 2013, revealed a wheelchair was prescribed for safe mobility.</p> <p>At the time of the survey, there was no evidence the facility closely monitored Client #3's wheelchair to ensure it was maintained in good condition.</p>	W 436	<p>The seat cushion has since been repaired. All staff have been counseled and trained on reporting any and all adaptive equipment issues in a timely manner. Once an issue is identified with any adaptive equipment the QIDP will report the issue on DDS website and immediately initiate the repair.</p>	12-30-13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  12/13/2013
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from December 11, 2013, through December 13, 2013. A sample of three residents was selected from a population of six individuals with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews, and the review of records, including incident reports.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Clinical Director (CD) Chief Operating Officer (COO) Director of Nursing (DON) Direct Support Professional (DSP) Group Home for Individuals with Intellectual Disabilities (GHIID) Intermediate Care Facility (ICF) Incident Management Coordinator (IMC) Individual Support Plan (ISP) Individualized Program Plan (IPP) Licensed Practical Nurse (LPN) Physical Therapist (PT) Qualified Intellectual Disabilities Professional (QIDP) Registered Nurse (RN) Emergency Room (ER) Facility Coordinator (FC)</p>	I 000		
I 090	<p><b>3504.1 HOUSEKEEPING</b></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>	I 090		

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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I 090	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on observation, and interview, the group home for individuals with intellectual disabilities (GHIID) failed to maintain the environment in accordance with the needs of six of the six residents of the facility. (Residents #1, #2, #3, #4, #5, and #6.</p> <p>The findings include:</p> <p>On December 13, 2013, at 10:30 a.m., the facility's coordinator (FC) #1 accompanied the surveyor to conduct an inspection of the environment.</p> <p>The GHIID failed to ensure that the interior environment was maintained in a safe and sanitary manner free, as evidenced below:</p> <p>1. Interview with the FC on December 13, 2013, at 10:42 a.m., revealed that all of the residents used wheelchairs for mobility and required the use of the shower chair or the shower gurney during bathing to ensure their safety.</p> <p>a. On December 13, 2013, at 10:34 a.m. and 10:42 a.m., respectively, a large amount of a black substance was observed on the back of the mesh cover installed on the shower chair located in the showers of both bathrooms.</p> <p>Interview with the FC on December 13, 2013, at 10:43 a.m., revealed the origin of the black substance was unknown.</p> <p>At the time of the survey, the facility failed to ensure shower chairs were maintained in a sanitary manner, free from heavily stained areas.</p>	I 090	<p>All mesh on the back of the shower chairs have since been cleaned and sanitized and are now free of the black substance on the back of them. Staff have been counseled on effectively cleaning, deodorizing and sanitizing each shower chair as well as the shower gurney after each use to avoid unwanted substance build-up.</p> <p>The Program Coordinator will check the shower chair and other bathroom equipment at least 3X weekly to assure compliance with cleaning these items.</p>	12-30-13

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I 090	<p>Continued From page 2</p> <p>b. On December 13, 2013, at 10:41a.m., observation of the vinyl covered pad on the shower gurney located in the east bathroom revealed multiple cracked areas on the top surface permitting the foam underneath to be exposed.</p> <p>Interview with the FC on December 13, 2013, at 10:42 a.m., indicated that the shower gurney pad had to be thoroughly cleaned after each shower, which reduced the life of the shower pad.</p> <p>At the time of the survey, the facility failed to ensure the vinyl covering on the shower gurney pad was maintained free of cracks to prevent prevent water from entering the foam padding underneath.</p> <p>2. On December 13, 2013, at 10:44 a.m., observation of the ceramic tiles installed on the floor of the east bathroom revealed the grout between the tiles was heavily stained and was dark gray in color. Intermittent areas of white grout were noted between some of the tiles.</p> <p>Interview with the FC on December 13, 2013, 10:45 a.m., revealed the COO had put in a request to have the floors stripped throughout the facility.</p> <p>At the time of the survey, the facility failed to ensure the bathroom floor tiles were maintained in a clean condition.</p>	I 090	<p>The shower gurney pad has been replaced. In the future the supervisors in the home will ensure to observe all adaptive equipment at least 3X weekly to assure that they are in good repair. Staffs have also been counseled on reporting equipment issues and needed repairs. All identified issues or necessary repairs will be immediately addressed.</p> <p>The Facility Coordinator and COO have since contacted a contractor to repair/replace the ceramic tiles. All are meeting on 1-9-14 to identify the necessary measures needed to fix/repair the tiles. Once identified, the work on the tiles will immediately be initiated.</p>	<p>12-30-13</p> <p>1-27-14</p>