

PRINTED: 11/25/2013  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER: **RCM**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **4954 ASTOR PLACE, SE 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) COMPLETE DATE
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1 000 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 varying degrees of intellectual disabilities. During the course of the survey, a comprehensive review of Residents #1's health care and nutritional status was conducted.

The findings of the survey were based on observations, interviews, and the review of records, including incident reports.

Note: The below are abbreviations that may appear throughout the body of this report.

- 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)
- Multi Wound Chart Notes Document Detail (MWCNDD)
- Licensed Practical Nurse (LPN)
- Physical Therapist (PT)
- Qualified Intellectual Disabilities Professional (QIDP)
- Registered Nurse (RN)
- Emergency Room (ER)
- Gastrointestinal Tube (G-Tube)

1 206 3509.6 PERSONNEL POLICIES

Each employee, prior to employment and annually thereafter, shall provide a physician's

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1 206

*Received 12/4/13*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6809

OJDR11

*12/4/13*

If continuation sheet 1 of 4

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I 206	<p>Continued From page 1</p> <p>certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHID failed to ensure that all employees and health care professionals had current health certificates on file, for 3 of 16 DSPs (DSPs #3, #5 and #16), 1 of 7 LPNs (LPN #3) and 2 of 7 consultants. (Consultants #1 and #2)</p> <p>The findings include:</p> <p>On November 7, 2013, beginning at 9:42 a.m., review of the personnel records for all employees, including licensed professional health consultants and nurses, revealed the following:</p> <ol style="list-style-type: none"> <li>1. There was no evidence of a complete physician's health inventory/certificate for the primary care physician (Consultant #1) and nutritionist (Consultant #2).</li> <li>2. There was no evidence of a complete physician's health inventory/certificate for DSPs #3, #5 and #16.</li> <li>3. There was no evidence of a complete physician's health inventory/certificate for LPN #3.</li> </ol> <p>At approximately 1:55 p.m., the COO, who had facilitated the review, acknowledged the aforementioned findings. No additional information was made available for review before the survey ended later that day.</p>	I 206	<p>1. The Primary Care Physician's Health Certificate, and the nutritionist's are currently on file 11-15-13 Refer to attachment #1a &amp; 1b</p> <p>2. The Health Certificates for DSPs #3 is currently on file 11-15-13 Refer to attachment # 2 The Health Certificates for DSPs #5 and #16 will be on file on 12-9-13</p> <p>3. The Health Certificate for LPN #3 will be on file on 12-9-13 In the future, the provider will ensure that all the personnel files are up to date, and available upon request.</p>	

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I 401	<p><b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each individual received professional services in accordance with their needs one of three residents of the sample. (Resident #1)</p> <p>The findings include:</p> <p>The facility failed to ensure that Resident #1's physician's order for supplemental feedings of Two Cal HN via gastrostomy tube was implemented timely to prevent weight loss and to promote healing of the pressure ulcers.</p> <p>On November 7, 2013, at approximately 7:00 p.m., LPN #2 was observed providing wound care treatment to Resident #1's Stage 3 pressure ulcers on the right and left ischium. Additionally, a dressing was observed covering Resident #1's left heel. Interview with LPN #2 at approximately 7:08 p.m. revealed that Resident #1 also had a pressure ulcer on the left heel, which was treated every three days (last treated on November 4, 2013) and covered with an Optifoam boarder.</p> <p>On November 7, 2013, at approximately 7:30 p.m., review of the MWCNDD dated October 31, 2013, revealed it recommended that Resident #1 be re-positioned every hour while sitting in the</p>	I-401	<p>The facility's RN was inserviced by the DON Consultant on the importance of the timely implementation of the telephone order of resident #1 on 12-3-13 Refer to attachment #3</p> <p>In the future, the nursing management will ensure that all of the individuals' telephone orders are implemented as prescribed and in a timely manner in order to prevent the delay in care, and to provide the best possible care as stipulated in the Health and Wellness Standards of practices.</p>	
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I.401	<p>Continued From page 3</p> <p>wheelchair. Further review revealed that the wound on the right Ischial had deteriorated and had increased in size and depth (7 X 4 X 2.3) and had doubled in size since October 17, 2013. Additionally, the wound on the left heel had increased in size and the area was friable (1 x 0.6 x 0).</p> <p>Interview with the primary RN on November 8, 2013, at 12:39 p.m., revealed Resident #1 had also had a significant weight loss in September 2013. Upon being informed of Resident #1's weight loss (October 2, 2013), the primary RN informed the PCP and was instructed to write a telephone order to resume the Two Cal HN, 1 can (240 cc), up to 3 times a day when the resident consumed less than 50% of her meal. Further interview with the primary RN revealed the telephone order was not implemented until October 17, 2013, because it was not in Resident #1's medical record.</p>	I.401	<p>The facility's RN was inserviced by the DON Consultant on the importance of the timely implementation of the telephone orders of resident #1 on 12-3-13 Refer to attachment #3</p> <p>In the future, the nursing management will ensure that all of the individuals' telephone orders are implemented as prescribed, and on the timely matter in order to prevent the delay in care, and to provide the best possible care as stipulated in the Health and Wellness Standards of practices.</p>	

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

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W 000	<p><b>INITIAL COMMENTS</b></p> <p>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 varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process. During the course of the survey, a comprehensive review of Client #1's health care and nutritional status was conducted.</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 (GHID) Intermediate Care Facility (ICF) Incident Management Coordinator (IMC) Individual Support Plan (ISP) Multi Wound Chart Notes Document Detail (MWCNDD) Licensed Practical Nurse (LPN) Physical Therapist (PT) Qualified Intellectual Disabilities Professional (QIDP) Registered Nurse (RN) Emergency Room (ER) Gastrointestinal Tube (G-Tube)</p>	W 000			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS	W 149			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 12/4/13

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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W 149	<p>Continued From page 1</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to implement its incident management policy to ensure each client's health and safety, for two of five clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <p>The facility failed to ensure to implement its incident management policy on the completion of thorough investigations.</p> <p>Cross refer to W156. The facility failed to ensure the agency's policy on reporting results of investigations to the administrator within five days of the incident was consistently implemented.</p> <p>Review of the facility's investigation reports on November 6, 2013, beginning at 10:22 a.m., revealed the facility failed to report the results of two investigations within the required timeframe, as evidenced below:</p> <p>(a) On September 13, 2013, Client #2 was evaluated at the ER due to a fall from the van wheelchair lift. Review of the facility's internal investigation report dated September 27, 2013, revealed the results of the investigation were reported to the administrator nine working days after the incident occurred.</p> <p>(b) On June 25, 2013, the facility was notified that</p>	W 149	<p>It is RCM's policy that all of the incidents are reported as they occur, and that the incident reports are completed as written in the policy; additionally, the result of each investigation is completed within the required time frame. In these cases, the results of the investigations were not reported to the Administrator within five days as stipulated in the Incident Management Policy. All staff were inserviced on incident management policy with emphasis on incident reporting and protocol 11-12-13</p> <p>Refer to attachment #4</p> <p>In the future, the provider will ensure that the the results of all of the investigations are reported to the administration within the time frame as stipulated in the incident management policy.</p>	11-12-13
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W 149	<p>Continued From page 2</p> <p>on June 24, 2013, an anonymous caller alleged that Clients # 2 and #4 were "systematically" not being adequately cared for at their day program. Review of the facility's internal investigation report dated July 11, 2013, revealed the results were reported to the administrator eleven working days after notification of the incident.</p> <p>Interview with the facility's COO on November 8, 2013, at 11:57 a.m., revealed the incident management policy required that the results of all investigations be reported to the administrator and/or designee with five working days. Further discussion with the COO confirmed that the results of the aforementioned investigations were not reported to the administrator within five working days.</p> <p>On November 8, 2013, at approximately 12:15 p.m., review of the facility's incident management policy revealed the final investigative report shall be submitted no later than 5 working days following the incident report for individuals residing in the facility.</p>	W 149	<p>It is RCM's policy that all of the incidents are reported as they occur, and that the incident reports are completed as written in the policy; additionally, the result each investigation is completed within the required time frame. In these cases, the results of the investigations were not reported to the Administrator within five days as stipulated in the Incident Management Policy. All staff were inserviced on the incident management policy with emphasis on incident reporting and protocol</p>	11-12-13
W 156	<p><b>483.420(d)(4) STAFF TREATMENT OF CLIENTS</b></p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the outcome of investigations was reported to the administrator or designated representative within five working days of the</p>	W 156	<p>Refer to attachment #4</p> <p>In the future, the provider will ensure that the the results of all of the investigations are reported to the administration within the time frame as stipulated in the incident management policy.</p>	

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W 156	<p>Continued From page 3 incident, for two of the five clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <p>Review of the facility's investigation reports on November 6, 2013, beginning at 10:22 a.m., revealed the facility failed to report the results of two investigations within the required timeframe, as evidenced below:</p> <p>(a) On September 13, 2013, Client #2 was evaluated at the ER due to a fall from the van wheelchair lift. Review of the facility's internal investigation report dated September 27, 2013, revealed the results of the investigation were reported to the administrator nine working days after the incident occurred.</p> <p>(b) On June 25, 2013, the facility was notified that on June 24, 2013, an anonymous caller alleged that Clients # 2 and #4 were "systematically" not being adequately cared for at their day program. Review of the facility's internal investigation report dated July 11, 2013, revealed the results were reported to the administrator eleven working days after notification of the incident.</p> <p>Interview with the facility's COO on November 8, 2013, at 11:57 a.m., revealed the incident management policy required that the results of all investigations be reported to the administrator and/or designee with five working days. Further discussion with the COO confirmed that the results of the aforementioned investigations were not reported to the administrator within five working days.</p> <p>On November 8, 2013, at approximately 12:15</p>	W 156	<p>It is RCM's policy that all of the incidents are reported as they occur, and that the incident reports are completed as written in the policy; additionally, the result each investigation is completed within the required time frame. In these cases, the results of the investigations were not reported to the Administrator within five days as stipulated in the Incident Management Policy. All staff were inserviced on the Incident management policy with emphasis on incident protocol.</p> <p>In the future, the provider will ensure that the the results of all of the investigations are reported to the administration within the time frame as stipulated in the incident management policy.</p>	11-12-13	

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W 156	Continued From page 4 p.m., review of the facility's incident management policy revealed the final investigative report shall be submitted no later than 5 working days following the incident report for individuals residing in the facility.	W 156		
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was effectively trained to manage the provisions outlined in each client's physical therapy assessment, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #1's wheelchair was tilted back no more than ten (10) degrees to prevent increasing the pressure on the client's ischium and pelvis in accordance with the PT assessment, as evidenced below:</p> <p>On November 7, 2013, at approximately 5:00 p.m. and 6:00 p.m., Client #1 was observed sitting in a wheelchair that was tilted back between 11 - 12 degrees with the client's legs extended.</p> <p>On November 7, 2013, at approximately 7:00 p.m., LPN #2 was observed providing wound care treatment to Client #1's Stage 3 pressure ulcers</p>	W 189	<p>All staff were inserviced by the Physical Therapist on the repositioning of resident #1's wheelchair on September 30, 2013; however, the training seemed not to have been effective.</p> <p>All Staff were inserviced again by the Physical Therapist on resident #1's wheelchair repositioning on 11-15-13</p> <p>Refer to attachment #5</p> <p>In the future, the facility management will ensure that all staff are effectively trained to manage the provisions outlined on each individual's Physical Therapy assessment.</p>	

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W 189	<p>Continued From page 5</p> <p>on the right and left ischium. Additionally, a dressing was observed covering Client #1's left heel. Interview with LPN #2 at approximately 7:08 p.m., revealed that Client #1 also had a pressure ulcer on the left heel, which was treated every three days (last treated on November 4, 2013) and covered with an Optifoam boarder.</p> <p>On November 7, 2013, at approximately 7:30 p.m., review of the MWCNDD dated October 31, 2013, revealed it recommended that Client #1 be re-positioned every hour while sitting in the wheelchair. Further review revealed that the wound on the right ischial had deteriorated and had increased in size and depth (7 X 4 X 2.3) and had doubled in size since October 17, 2013. Additionally, the wound on the left heel had increased in size and the area was friable (1 x 0.6 x 0).</p> <p>On November 8, 2013, at approximately 11:35 a.m., interview with DSP #2 at 6:10 p.m., revealed that Client #1 was to be re-positioned every hour while sitting in the wheelchair. Additionally, DSP #2 revealed staff had been trained on how to change the client's position by tilting the handle on the wheelchair up and down. However, DSP #2 was unable to state how many degrees the client's wheelchair should be tilted.</p> <p>On November 8, 2013, at approximately 1:38 p.m., review of Client #1's PT assessment dated May 1, 2013, revealed it stated if the client is reclined back in the wheelchair more than 10 degrees, this would increase the pressure at the client's ischium and pelvis.</p> <p>On November 8, 2013, at approximately 2:05 p.m., review of the staff in-service training</p>	W 189	<p>All staff were inserviced by the Physical Therapist on the repositioning of resident #1's wheelchair on September 30, 2013; however, the training seemed not to have been effective.</p> <p>All Staff were inserviced again by the Physical Therapist on resident #1's wheelchair repositioning on 11-15-13</p> <p>Refer to attachment #5</p> <p>In the future, the facility management will ensure that all staff are effectively trained to manage the provisions outlined on each individual's Physical Therapy assessment.</p>		

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/08/2013</b>
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(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 189	Continued From page 6 records dated September 30, 2013, revealed that all staff had received training on Client #1's wheelchair re-positioning. Observations and interviews on November 7 and November 8, 2013, however, indicated that the training was not effective.	W 189			
W 331	<b>483.460(c) NURSING SERVICES</b>  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 nursing services failed to ensure a prescribed treatment was timely implemented for one of three clients in the sample. (Client #1)  The finding includes:  The facility failed to ensure that Client #1's physician's order for supplemental feedings of Two Cal HN via gastrostomy tube was implemented timely to prevent weight loss and to promote healing of the pressure ulcers.  On November 7, 2013, at approximately 7:00 p.m., LPN #2 was observed providing wound care treatment to Client #1's Stage 3 pressure ulcers on the right and left ischium. Additionally, a dressing was observed covering Client #1's left heel. Interview with LPN #2 at approximately 7:08 p.m. revealed that Client #1 also had a pressure ulcer on the left heel, which was treated every three days (last treated on November 4, 2013) and covered with an Optifoam boarder.	W 331	The facility's RN was inserviced by the DON Consultant on the importance of the timely implementation of the telephone orders of resident #1 on 12-3-13 Refer to attachment #3 In the future, the nursing management will ensure that all of the individuals' telephone orders are implemented as prescribed, and on a timely matter in order to prevent the delay in care, and to provide the best possible care as stipulated in the Health and Wellness Standards of practices.		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  RCM	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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(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
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W 331	<p>Continued From page 7</p> <p>On November 7, 2013, at approximately 7:30 p.m., review of the MWCNDD dated October 31, 2013, revealed it recommended that Client #1 be re-positioned every hour while sitting in the wheelchair. Further review revealed that the wound on the right ischial had deteriorated and had increased in size and depth (7 X 4 X 2.3) and had doubled in size since October 17, 2013. Additionally, the wound on the left heel had increased in size and the area was friable (1 x 0.6 x 0).</p> <p>Interview with the primary RN on November 8, 2013, at 12:39 p.m., revealed Client #1 had also had a significant weight loss in September 2013. Upon being informed of Client #1's weight loss (October 2, 2013), the primary RN informed the PCP and was instructed to write a telephone order to resume the Two Cal HN, 1 can (240 cc), up to 3 times a day when the client consumed less than 50% of her meal. Further interview with the primary RN revealed the telephone order was not implemented until October 17, 2013, because it was not in Client #1's medical record.</p>	W 331	<p>The facility's RN was inserviced by the DON Consultant on the importance of the timely implementation of the telephone orders of resident #1 on 12-3-13 Refer to attachment #3</p> <p>In the future, the nursing management will ensure that all of the individuals' telephone orders are implemented as prescribed, and on a timely matter in order to prevent the delay in care, and to provide the best possible care as stipulated in the Health and Wellness Standards of practices.</p>	
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