

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER
RCM OF WASHINGTON, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
**617 DAHLIA STREET, NW
WASHINGTON, DC 20011**

(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
1 000	INITIAL COMMENTS A licensure survey was conducted from September 4, 2013 through September 6, 2013. A sample of three residents was selected from a population of five females and one male with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident's family/guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000		
1 401	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 GHIID's nursing services failed to ensure one out of the three sampled resident's wheelchair was set at the correct angle/degrees after being fed in accordance with the speech and language assessment. (Resident #3) The finding includes:	1 401		

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: Angele Eganola TITLE: Program Director (X6) DATE: 9-24-13

STATE FORM 5895 Z1NF1 If continuation sheet 1 of 3

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1401	<p>Continued From page 1</p> <p>The facility's nursing personnel staff failed to ensure Resident #3's wheelchair was set to the appropriate angle/degrees, as recommended.</p> <p>Observation conducted at the day program on September 4, 2013, beginning at 12:02 p.m., revealed Resident #3 was sitting in a custom molded wheelchair in the classroom. Day program staff (DPS) #1 stated that the resident was just fed via G-tube thirty-minutes (30) earlier. Continued observation of Resident #1's wheelchair revealed the angle was set between 30 and 40 degrees. Later that evening at 5:20 p.m., Resident #3 was fed 1.2 Jevity Cal liquid (120 cc) via G-tube. After the feeding at 5:40 p.m., Resident #3 was transported back to the living room area with her peers and staff. A few moments later, observations revealed the resident's wheelchair angle appeared to be set at between 0 and 15 degrees. At 5:42 p.m., the licensed practical nurse (LPN) #2 was asked, what angle should Resident #2's wheelchair be set at after feeding? LPN #2 replied by saying, "he could not recall what angle Resident #3's wheelchair should be set at after feeding". Moments later, DSS #1 who overheard the surveyor's question to LPN #2 came into the living room and stated that the wheelchair angle should be set between 30 and 40 degrees. When asked at approximately 5:45 p.m., LPN #2 stated that he had received training on Resident #3's swallowing/feeding guidelines.</p> <p>The facility's licensed practical nurse coordinator (LPNC) #1 was interview on September 4, 2013, at approximately 7:15 p.m., to ascertain whether all nursing staff had received training on Resident</p>	1401	<p>It is RCM's policy that all staff including nurses are trained on the individuals' mealtime protocols, and on Speech and language assessment. LPN # 2 was retrained on individual # 3's mealtime protocol and Speech and language assessment on 9-6-13</p> <p>Refer to attachment # 1.</p> <p>In the future, the facility nursing management will ensure that staff including nurses are trained on the individuals' diets and recommendations are implemented as prescribed by the clinicians.</p>	9-6-13
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Continued From page 2

#3's speech and language assessment. LPNC #1 stated that all nursing staff including LPN #2 had received training on Resident #3's swallowing/eating guidelines.

On September 5, 2013, at 3:45 p.m., review of the Resident #3's speech and language assessment dated July 2, 2013, revealed the resident should be in an upright position (approximately 30-45 degrees) one hour after feeding. At approximately 3:50 p.m., review of the physician's orders dated September 2013, revealed the resident's head should be elevated between 30 and 40 degrees one hour after feeding.

I 401

It is RCM's policy that all staff including nurses are trained on the individuals' mealtime protocols, and on Speech and language assessment. LPN # 2 was retrained on individual #'3 mealtime protocol and Speech and language assessment on 9-6-13

Refer to attachment # 1. In the future, the facility nursing management will ensure that staff including nurses are trained on the individuals's diets and Speech and Language assessment and implement the recommendations as prescribed by the clinicians.

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R 000 INITIAL COMMENTS

A licensure survey was conducted from September 4, 2013 through September 6, 2013. A sample of three residents was selected from a population of five females and one male with varying degrees of intellectual disabilities.

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

R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125

The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.

This Statute is not met as evidenced by:
Based on interview and review of personnel records, the group home for individuals with intellectual disabilities (GHID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 2 out of 17 staff. (Staff #2 and #9)

The findings include:

1. On September 6, 2013, beginning at 12:07 p.m., review of the personnel record for Staff #2 revealed that background checks had been obtained at the time of hire. The background checks covered the District of Columbia and

Staff #2's background information is currently on file 9-10-13
Refer to attachment #2
In the future, the provider will ensure that all of the employees' files are up to date, and provided upon request.

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

Angela B. Blum

TITLE

Program Director

(X6) DATE

9-24-13

STATE FORM

6699

Z11F11

If continuation sheet 1 of 2

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R 125	<p>Continued From page 1</p> <p>Maryland. Her employment application form, dated May 21, 2012, indicated that she had been employed in Seattle Washington from July 2006 through December 2009. There was no evidence that a background check had been obtained in that jurisdiction.</p> <p>2. On September 6, 2013, beginning at 12:07 p.m., review of the personnel record for Staff #9 revealed that background checks had been obtained at the time of hire. The background checks covered the state of Virginia. Her employment application form indicated that she currently works in the District of Columbia. Interview with Staff #9 on September 6, 2013, at approximately 2:50 p.m., revealed that she only obtained a background check for the state of Virginia. There was no evidence that a background check had been obtained for the District of Columbia.</p> <p>On September 6, 2013, at approximately 2:30 p.m., interview with the facility's program director (PD) verified that the aforementioned findings listed above that criminal background checks were not conducted in all jurisdictions where staff worked and/or lived within the past seven years.</p>	R 125	<p>Staff #9's background information is currently on file 9-9-13</p> <p>Refer to attachment #3</p> <p>In the future, the provider will ensure that all of the employees' files are up to date, and provided upon request.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from September 4, 2013 through September 6, 2013. A sample of three clients was selected from a population of five females and one male with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one client's family member/guardian, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000		
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services repositioned each client that was wheelchair bound, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p>	W 120		

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

Angelo Ejanilla *Program Director* *9-24-13*

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 120	<p>Continued From page 1</p> <p>On September 4, 2013, observations conducted at the day program from 12:02 p.m. to 1:35 p.m. revealed Client #2 remained seated in her wheelchair. At 12:30 p.m., day program staff (DPS) #2 walked into the classroom and stated, "I'm getting ready to reposition Client #2 out of her wheelchair". Day program case manager (DPCM) #1 who was observed standing inside the classroom at the time, stated to DPS #2, "let the <client name> rest".</p> <p>Interview with DPS #1 on September 4, 2013, at 1:05 p.m., revealed that he repositioned Client #2 out of her wheelchair earlier that morning between 9:30 a.m. and 9:45 a.m. but did not document it on the repositioning log book. At 1:17 p.m., interview with DSP #2 revealed that she was responsible for repositioning the client every 2 hours. DSP #2 stated however, that she had not repositioned Client #2 today. This was verified through review of the September 2013 repositioning log at approximately 1:40 p.m.</p> <p>On September 4, 2013, at approximately 1:50 p.m., review of the POs dated September 2013 revealed the client should be repositioned every 2 hours. At the time of the survey, the day program staff failed to ensure Client #2 was repositioned every two (2) hours to avoid potential skin breakdown in accordance with the current physician's orders (POs).</p>	W 120	<p>All day program staff working with individual#3 were inserviced by the Program Director on 9-24-13. The emphasis of the inservice was the schedule, and importance of the repositioning. Refer to attachment #4. In the future, the facility management, mainly the QIDP will ensure that individual #3 as well as other individuals are repositioned at their day programs as recommended by the PT. The QIDP will monitor the reposition during the monthly visits as well as the pop up visits. The QIDP will review the repositioning log to ensure that continued treatment is provided as prescribed.</p>
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,</p>	W 189	

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W 189	<p>Continued From page 2 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 that staff was effectively trained to manage the provisions outlined in each client's Occupational Therapy (OT) assessment, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Observation conducted at the day program on September 4, 2013, beginning at 12:02 p.m., revealed Client #3 was sitting in a custom molded wheelchair in the classroom. Day program staff (DPS) #1 stated that the client was just fed via G-tube thirty-minutes (30) earlier. Continued observation of Client #1's wheelchair revealed the angle was set between 30 and 40 degrees. Later that evening at 5:20 p.m., Client #3 was fed 1.2 Jevity Cal liquid (120cc) via G-tube. After the feeding at 5:40 p.m., Client #3 was transported back to the living room area with her peers and staff. A few moments later, observations revealed the client's wheelchair angle appeared to be set at between 0 and 15 degrees.</p> <p>At 5:42 p.m., the licensed practical nurse (LPN) #2 was asked, what angle should Client #2's wheelchair be set at after feeding? LPN #2 replied by saying, "he could not recall what angle Client #3's wheelchair should be set at after feeding". Moments later, DSS #1 who overheard the surveyor's question to LPN #2 came into the living room and stated that the wheelchair angle should be set between 30 and 40 degrees. When asked at approximately 5:45 p.m., LPN #2</p>	W 189	<p>It is RCM's policy that all staff including nurses are trained on the individuals' mealtime protocols, and on Speech and language assessment. LPN # 2 was retrained on individual # 3's mealtime protocol and Speech and language assessment on 9-6-13</p> <p>Refer to attachment # 1. In the future, the facility nursing management will ensure that staff including nurses are trained on the individuals's diets and Speech and Language assessment</p>	9-6-13

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W 189	Continued From page 3 stated that he had received training on Client #3's feeding guidelines. The facility's licensed practical nurse coordinator (LPNC) #1 was interviewed on September 4, 2013, at approximately 7:15 p.m., to ascertain whether all nursing staff had received training on Client #3's eating guidelines. LPNC #1 stated that all nursing staff including LPN #2 had received training on Client #3's eating guidelines. Review of the staff in-service training records on September 6, 2013, at approximately 1:48 p.m., revealed LPN #2 received training on G-tube and aspirations precautions on July 29, 2013, for Client #2. There was no evidenced that training on September 4, 2013.	W 189		
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's nursing services failed to ensure one out of the three sampled client's wheelchair was set at the correct angle/degrees after being fed in accordance with the speech and language assessment. (Client #3) The finding includes: The facility's nursing personnel staff failed to	W 331		

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W 331	<p>Continued From page 4</p> <p>ensure Client #3's wheelchair was set to the appropriate angle/degrees, as recommended.</p> <p>Observation conducted at the day program on September 4, 2013, beginning at 12:02 p.m., revealed Client #3 was sitting in a custom molded wheelchair in the classroom. Day program staff (DPS) #1 stated that the client was just fed via G-tube thirty-minutes (30) earlier. Continued observation of Client #1's wheelchair revealed the angle was set between 30 and 40 degrees. Later that evening at 5:20 p.m., Client #3 was fed 1.2 Jevity Cal liquid (120 cc) via G-tube. After the feeding at 5:40 p.m., Client #3 was transported back to the living room area with her peers and staff. A few moments later, observations revealed the client's wheelchair angle appeared to be set at between 0 and 15 degrees. At 5:42 p.m., the licensed practical nurse (LPN) #2 was asked, what angle should Client #2's wheelchair be set at after feeding? LPM #2 replied by saying, " he could not recall what angle Client #3's wheelchair should be set at after feeding". Moments later, DSS #1 who overheard the surveyor's question to LPN #2 came into the living room and stated that the wheelchair angle should be set between 30 and 40 degrees. When asked at approximately 5:45 p.m., LPN #2 stated that he had received training on Client #3's swallowing/feeding guidelines.</p> <p>The facility's licensed practical nurse coordinator (LPNC) #1 was interview on September 4, 2013, at approximately 7:15 p.m., to ascertain whether all nursing staff had received training on Client #3's speech and language assessment. LPNC #1 stated that all nursing staff including LPN #2 had</p>	W 331	<p>It is RCM's policy that all staff including nurses are trained on the individuals' mealtime protocols, and on Speech and language assessment. LPN # 2 was retrained on individual # 3's mealtime protocol and Speech and and language assessment on</p> <p>Refer to attachment # 1. In the future, the facility nursing management will ensure that staff including nurses are trained on the individuals's diets and Speech and Language assessment</p>	9-6-13

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W 331	<p>Continued From page 5 received training on Client #3's swallowing/eating guidelines.</p> <p>On September 5, 2013, at 3:45 p.m., review of the Client #3's speech and language assessment dated July 2, 2013, revealed the client should be in a an upright position (approximately 30-45 degrees) one hour after feeding. At approximately 3:50 p.m., review of the physician's orders dated Septemtier 2013, revealed the client's head should be elevated between 30 and 40 degrees one hour after feeding.</p>	W 331	<p>It is RCM's policy that all staff including nurses are trained on the individuals' mealtime protocols, and on Speech and language assessment. LPN # 2 was retrained on individual # 3's mealtime protocol and Speech and language assessment on . Refer to attachment # 1. In the future, the facility nursing management will ensure that staff including nurses are trained on the individuals's diets and Speech and Language assessment</p>	