

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/03/2013
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NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 R STREET SE WASHINGTON, DC 20020
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1 000	INITIAL COMMENTS A licensure survey was conducted from April 2, 2013, through April 3, 2013. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home, interviews with residents, 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 Support Coordinator (SC) within this report.]	1 000	<p style="text-align: center;"><i>Received</i> <i>April 26/2013</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
1 422	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) failed to ensure that resident's training objective (wipe his mouth) was implemented in accordance with their individual support plan (ISP), for one of the three residents included in the sample. (Resident #3) The finding includes: Facility staff failed to encourage and facilitate implementation of Resident #3's wiping his mouth training program, as follows: On April 2, 2013, at 4:13 p.m. Resident #3 was	1 422		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Aloua Joseph* 4/26/13 TITLE: *Director of Community Affairs* (X6) DATE: *4/26/13*

STATE FORM 6899 WH4311 If continuation sheet 1 of 6

Health Regulation & Licensing Administration

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I 422	<p>Continued From page 1</p> <p>observed blowing bubbles from his mouth while seated at the dining room table. The resident and his housemates (Residents #1, #4, #5 and #6) sat at the table with him preparing to receive their evening snack. Resident #3 was also observed to blow bubbles from his mouth when his saliva landed on the table. Although the resident was provided with hand over hand assistance with his snack, the direct support professional #1 (DSP#1) at no time was observed to assist Resident #3 to wipe his mouth during the snack from 4:13 p.m. until 4:34 p.m. when the resident finished his snack.</p> <p>Interview with the Support Coordinator (SC) on April 3, 2013, at 10:59 a.m. revealed Resident #3 was known to blow bubbles all of the time. According to the SC, the resident had a training objective to wipe his mouth after eating his meals. The surveyor verified a training objective on the same day at 11:14 a.m. from the electronic record that revealed Resident #3 had a program objective to wipe his mouth with hand over hand assistance from staff on 80% trials for three consecutive months.</p> <p>Further review of the resident's electronic record revealed data collection for the aforementioned program objective for the months of February 2013 and March 2013. The review of the data collection revealed staff failed to implement the training objective for Resident #3 to wipe his mouth for the following dates:</p> <p>February 16, 2013 through February 20, 2013 February 22, 2012 through February 24, 2013 February 27, 2013 through February March 1, 2013 March 12, 2013 through March 29, 2013</p>	I 422	<p>All staff were re-trained on this objective and the documentation of all objective on 4-19-13. As follow up training is scheduled for 5-3-13 for all staff to ensure that the information was retained.</p> <p>4-19-13</p>

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I 422	Continued From page 2 At the time of the survey, the facility's direct support staff failed to implement Resident #3's training objective to wipe his mouth.	I 422	All staff were re-trained on this objective and the documentation of all objective on 4-19-13. As follow up training is scheduled for 5-3-13 for all staff to ensure that the information was retained.	4-19-13
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District laws that govern the care and rights of persons with mental retardation, for one resident included in the sample. (Resident #1) The finding includes: (Chapter 13, § 7-1305.05. (h) The GHIID failed to ensure that timely written consent was obtained from Resident #1's court appointed legal guardian for the increase of his psychotropic medication. During the entrance interview with the facility's Support Coordinator (SC) on April 2, 2013, at approximately 8:52 a.m. revealed Resident #1 had a Behavior Support Plan (BSP) to address his self-injurious behaviors (SIB), i.e. wrist biting and hand biting. Further interview with the SC revealed the resident was also prescribed	I 500		

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I 500	<p>Continued From page 3</p> <p>psychotropic medications to address his targeted behaviors. The SC revealed Resident #1 had a court-appointed guardian to assist with healthcare decisions due to the resident's lack of capacity to give informed consent for the use of his medications.</p> <p>The SC statements were verified on April 2, 2013, at approximately 1:59 p.m., through review of Resident #1's psychological assessment dated June 24, 2008. According to the assessment, Resident #1 did not evidence the capacity to make independent decisions on his own behalf regarding his habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation."</p> <p>Interview with the licensed practical nurse coordinator (LPNC) on April 2, 2013, beginning at 10:15 a.m. revealed Resident #1 had a change in his medication regimen. According to the LPNC, the resident was prescribed Zyprexa 10 milligrams (MG). Continued discussion with the LPNC revealed on April 1, 2012, the facility's pharmacist delivered Olanzapine (generic brand) 10 mg instead of the Zyprexa 10 mg. The LPNC also revealed that the resident began to experience an increase in his SIB behaviors when administered the generic brand Olanzapine 10 mg. Further interview with the LPNC and review of the electronic records revealed a psychotropic medication review dated April 18, 2012. Review of the aforementioned psychotropic medication review revealed the psychiatrist made a recommendation to increase the resident's Zyprexa 15 mg "generic to compensate for the lost potency of the "brand" because of the dramatic changes in Resident #1's behaviors.</p>	I 500	

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I 500	<p>Continued From page 4</p> <p>Interview with the facility's Director of Nursing (DON) and the LPNC on April 3, 2013, at 10:54 a.m. revealed that the generic brand (Olanzapine 15 mg) for Zyprexa was not administered until the following month (April 2012) due to the absence of an informed consent from Resident #1's legal guardian. Immediately following the interview, the nursing staff provided a written physician's order signed by the resident's primary care physician (PCP) dated April 19, 2012, the day after his psychotropic medication review (April 18, 2012) for Olanzapine 10 mg tab q p.m. until consent and human rights approval obtained. Another order with the same date, April 19, 2012, signed by the resident's PCP revealed "then start Zyprexa as ordered, Zyprexa 15 mg qd once a day in p.m."</p> <p>Further review of the resident's electronic medical records on April 2, 2013, at approximately 11:20 a.m. revealed a psychotropic medication review dated May 16, 2012. The following written comments made by the psychiatrist revealed "due to neglect, inappropriate, and unresponsive guardian [representative's name], medication will remain Zyprexa 10 mg. until he signs consent. It should be noted that the surveyor was provided with the consent for Zyprexa 15 mg dated May 19, 2012, one month after the psychiatrist ordered the increase on April 18, 2012.</p> <p>Review of Resident #1's medication administration record (MAR) on April 3, 2013, revealed the resident's Olanzapine 15 mg was first administered on April 19, 2012. At 1:04 p.m., review of the facility's Human Rights Committee (HRC) records revealed there were minutes dated June 11, 2012. Review of those meeting minutes, revealed no evidence that the HRC had</p>	I 500	<p>The Nurse for individual #2 and the Support Coordinator has contacted this individual's DDS Service Coordinator to discuss the guardian's timeliness in providing medical consent. The DDS Service Coordinator has since contacted DDS's attorney who has advised that the guardian will be removed and another one will be appointed as this is an ongoing issue with this guardian. The process for removal was implemented on 4-24-13.</p>	4-24-13

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I 500	<p>Continued From page 5</p> <p>discussed whether Resident #1's medical guardian had provided written consent for his medications. The surveyor was provided with a copy of form entitled "Consent for Change in Medication." Review of the aforementioned form revealed Resident #1's court appointed guardian signed the consent for Zyprexa 15 mg on May 19, 2012.</p> <p>At the time of the survey, the facility failed to ensure consent was provided before the administration of Resident #1's psychotropic medication (Zyprexa 15 mg).</p>	I 500	<p>In the future the Support Coordinator will ensure that discussions regarding the guardian's consent is discussed at all HRC meetings if warranted to ensure that it is thoroughly documented.</p> <p>Emergency HRC consent was provided prior to the administration of the medication; however, the Support Coordinator failed to ensure that it was presented at the next HRC meeting for documentation. In the future the Support Coordinator will ensure that all emergency approvals are presented for documentation in the HRC minutes.</p>	<p>4-19-13</p> <p>4-19-13</p>
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