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

PRINTED: 06/21/2013
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
	09G228	A. BUILDING _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2420 T STREET, SE WASHINGTON, DC 20020

(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 000	INITIAL COMMENTS A recertification survey was conducted from June 6, 2013 through June 7, 2013. A random sample of three clients was selected from a population of five females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and one day program, interview with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	Received 6/27/13 DOH-HRL-IICFD	
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the specially constituted committee reviewed and approved sedation administered prior to an appointment for one of three clients in the sample. (Client #3) The finding includes: On June 7, 2013 on 12:15 p.m., interview with the	W 262		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 6/27/13

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 262	Continued From page 1 facility's registered nurse (RN) revealed Client #3 sometime required sedation prior to an appointment to improve her cooperation. On June 7, 2013, at 12:32 p.m., the review of a dental consultation report dated July 5, 2012 revealed, "Patient [Client #3] fussed and refused treatment today. Please sedate patient for next dental appointment." Continued record review at 12:37 p.m. revealed a telephone physician's order dated July 30, 2012, that prescribed Xanax 5 milligram (mg) by mouth one hour prior next dental appointment. Review of a dental consultation report dated August 23, 2012 on June 7, 2013 at 12:47 p.m., revealed the client was sedated for completion of the periodic oral exam, prophylaxis, and fluoride treatment. On June 7, 2013 at 12:52 p.m., interview with the registered nurse (RN) and the director of nursing (DON) confirmed that Client #3 was sedated for the dental appointment on August 23, 2012. Further discussion with the RN and the DON on June 7, 2013 at 1:15 p.m. revealed it was the agency's policy to obtain prior review and approval of all sedation by the Human Rights Committee (HRC) before it is administered to any client. The RN and the DON stated however, that there were no record of the HRC review and approval for the Xanax 5 mg prescribed for Client #3 on July 30, 2012. The DON indicated that she would follow up with the program director to ascertain if additional HRC minutes were available. On June 7, 2013, at 1:18 p.m., review of the HRC meeting minutes dated July 16, 2012, August 13, 2012, and September 17, 2012 revealed there	W 262	It is RCM's policy that all medications used for sedation are approved by the Human Rights Committee before they are administered to the individuals. In this case, the consent was approved by individual #3's Guardian;however, the QIDP failed to request the approval by the Human Rights Committee prior to the dental appointment scheduled for August 23,2012. Even though the time has passed, the use of Xanax 5mg was presented,and approved by the Human Rights Committee on 6-17-13 Refer to attachment #1 In the future, the facility management will ensure that all medications used for sedation are reviewed, and approved by the specially constituted committee prior to their administration.	

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W 262	Continued From page 2 was no documentation to verify a review or approval for the Xanax 5 mg administered to Client #3. At the time of the survey, however, there was no evidence that the Xanax 5 mg administered to Client #3 on August 23, 2013 was reviewed and approved by the HRC.	W 262	It is RCM's policy that all medications used for sedation are approved by the Human Rights Committee before they are administered to the individuals. In this case, the consent was approved by individual #3's Guardian;however, the QIDP failed to request the approval by the Human Rights Committee prior to the dental appointment scheduled for August 23,2012 Even though the time has passed, the use of Xanax 5mg was presented,and approved by the Human Rights Committee on 6-17-13 Refer to attachment #1 In the future, the facility management will ensure that all medications used for sedation are reviewed, and approved by the specially constituted committee prior to their administration.	

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 6, 2013 through June 7, 2013. A random sample of three residents was selected from a population of five females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and one day program, interview with 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.]	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) failed to maintain the environment in accordance with the needs of five of the five residents in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: On June 7, 2013, beginning at 2:50 p.m. the surveyors were accompanied by the residential	I 090		

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I 090	Continued From page 1 director to conduct an inspection of the environment. The findings identified in this report were confirmed by the residential director. 1. The large area rug on floor of the living room was heavily soiled. 2. A stack of five plastic oblong pans was observed stored in bathroom #1. Closer observation of the pans revealed each contained an accumulation of a white substance on the interior, which appeared to be soap scum. Interview with direct support staff (DSP #9) on June 7, 2013 at 4:08 p.m., revealed the pans were used when it was necessary to give the residents bed baths. Interview with the residential director acknowledged that the pans were soiled and that they should be cleaned after each use to ensure they are maintained in a sanitary condition.	I 090	1. The large area rug on the floor of the living room was discarded, and replaced on 6-12-13 In the future, the facility management will ensure that the facility is clean, orderly, attractive in a sanitary manner. 2. All of the plastic oblong pans were cleaned, and placed inside the bathroom cabinet on 6-7-13 All staff were inserviced on the infection control and the care of the hygiene kits on 6-11-13 Refer to attachment #2.	
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 persons with	I 379	In the future, the facility management will ensure that all the containers used for potential bed bath are maintained in a sanitary condition.	

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I 379	Continued From page 2 Intellectual disabilities (GHIID) failed to ensure written notification of an emergency room visit was provided within 24 hours to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the three residents in the sample. (Resident #3) The finding includes: On June 7, 2013 at 11:32 p.m., the review of a primary care physician's progress note dated March 22, 2013 revealed Resident #3 was evaluated at the emergency room on March 21, 2013 due to a fall from her wheelchair at the day program. The review of facility's incidents presented to the surveyors revealed no incident dated March 21, 2013 was included. At approximately 12:30 p.m., the facility's qualified intellectual disabilities professional (QIDP) provided a copy of an incident report, dated March 21, 2013. Interview with QIDP and the residential director (RD) on June 7, 2013 at 11:41 a.m., verified that Resident #3 was evaluated at the emergency room on March 21, 2013 after her fall from the wheelchair at the day program. The QIDP indicated that he notified the DOH incident management coordinator by telephone on the day of the incident. On June 7, 2013 at approximately 12:30 p.m., the QIDP provided documentation to confirm Resident #3's fall from her wheelchair was verbally reported to the DOH by telephone on March 21, 2013. Review of the written incident report, however failed to provide evidence that it was submitted to DOH. At the time of the survey, the facility failed to	I 379	Is it RCM's Policy that all incidents are reported, and submitted to the appropriate parties. Individual #3's incident that occurred on March 21, 2013 was reported to the appropriate parties, including DOH, but the QIDP failed to submit the incident report to this entity. The QIDP was inserviced on the Incident Management Policy and Incident Reporting Protocol by the Incident Management Coordinator on 6-18-13 Refer to attachment #3. The discipline action was implemented as well. Refer to attachment #4 In the future, the facility's QIDP will ensure that all incidents are reported, and timely submitted to the appropriate parties.	

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I 379	Continued From page 3 ensure a written incident report to document Resident #3's fall from her wheelchair at her day program was provided to the DOH/HRLA within 24 hours as required,	I 379		