

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2009
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NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON	STREET ADDRESS, CITY STATE ZIP CODE 1307 45TH 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)	(X) 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 February 4, 2008 through February 9, 2008. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with the direct care staff and the administrative staff, as well as the review of clinical and administrative records, including incident reports.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

Received 2/18/09

{222} 3510.3 STAFF TRAINING

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.

The findings include:

Observation on February 4, 2009, at 3:51 PM revealed Resident #1 entering the facility with the assistance of a direct care staff member. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on February 4, 2009, at 9:00 AM revealed Resident #1 received one to one supervision and that he was visually blind. During the observation, Resident #1 was noted to walk independently in front of the one to one staff person (Staff #1).

At 3:53 PM, the 8:00 AM through 4:00 PM one to one staff person (Staff #2) was observed to accompany Resident #1 to the kitchen area for a

{222}

All staff were previously trained by the PT on client #1's ambulation protocol; however, by the training seemed not to be effective. The staff were retrained by the PT on client #1's ambulation protocol and fall prevention on 2-10-09 Refer to attachment # 1 a, 1b
Additionally, all staff were trained on client monitoring on 2-10-09 Refer to attachment # 1c
The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09 Refer to attachment #1d
In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:
[Signature]

TITLE: *Program Director* DATE: *3-13-09*

STATE FORM

6209

8KN672

Recreation sheet 1 of 3

Health Regulation Administration

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I 222	Continued From page 1 snack. The observation revealed the Resident walked with an unsteady gait as Staff #2 walked alongside of the Resident guiding him with her hand on the top of his head. At 5:07 PM, an administrative staff was observed holding both of Resident #1's hands and walking in front of him. Interview with the QMRP on February 5, 2009, revealed the Resident did not have an ambulation or walking protocol. The QMRP revealed that it was the one to one staff's responsibility to be in arms length of the client. Additionally, he indicated that the staff was to use "contact guard" assistance by placing their hand on the client's back or the Resident could place his hand on the one to one's back. Review of Resident #1's habilitation record on the aforementioned date revealed a physical therapy assessment dated October 13, 2008. According to the assessment, the physical therapist recommended to "provide the Resident with physical assistance for guidance during ambulation, and allow him to trail." During the entrance conference on February 4, 2009, at 10:45 AM, interview with the facility's House Manager (HM) revealed that the staff was inserviced several times on "Supervision/Resident Monitoring." Continued interview with HM and review of the facility's training record verified that the direct care staff had been trained on three different occasions, (August 16, 2008, October 3, 2008, and January 30, 2009). At the time of the survey, however, the facility failed to ensure direct care staff were effectively trained how to properly walk with Resident #1 safely and to ensure safety.	I 222	All staff were previously trained by the PT on client #1's ambulation protocol; however, the training seemed not to be effective. The staff were retrained by the PT on the client #1's ambulation protocol and fall prevention on 2-10-09 Refer to attachment # 1 a, 1b Additionally, all staff were trained on client monitoring on 2-10-09 Refer to attachment # 1c The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09 Refer to attachment #1d In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist. All staff were previously trained by the PT on client #1's ambulation protocol; however, the training seemed not to be effective. The staff were retrained by the PT on the client #1's ambulation protocol and fall prevention on 2-10-09 Refer to attachment # 1 a, 1b Additionally all staff were trained on client monitoring on 2-10-09 Refer to attachment # 1c The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09 Refer to attachment #1d In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist.	

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

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FORM APPROVED
OMB NO. 0938-0391

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{W 000}	INITIAL COMMENTS	{W 000}		
	<p>A revisit was conducted on February 4, 2009 to determine the facility's compliance with the deficiencies cited during the recertification survey on July 17, 2008. The visit was conducted to assess the effectiveness of the corrective actions employed by the facility as presented in their Plan of Correction (POC) dated August 1, 2008. Four males with varying degrees of disabilities reside in this facility. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. The findings of the revisit were based on observation, staff interviews, and the review of the client and administrative records, including the unusual incident reports.</p> <p>As a result of the survey, a determination was made that the facility maintained compliance with most of the previously cited deficiencies and new standard level deficiencies were identified.</p>			
{W 104}	483.410(a)(1) GOVERNING BODY	{W 104}		8/8/08
	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by. Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas.</p> <p>The findings include:</p> <p>Cross-refer to W154 The governing body failed to ensure that all incidents of unknown origin were thoroughly investigated in accordance with</p>			

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

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 104} Continued From page 1 {W 124} 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	<p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status attendant risks of treatment, and the right to refuse treatment, for one of the three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>1. The facility failed to ensure that informed consent was obtained from Client #1's surrogate decision maker prior to the administration of his psychotropic medication.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on February 4, 2009, at 9:00 AM revealed that Client #1 had a Behavior Support Plan (BSP) and received psychotropic medications to address his behaviors.</p> <p>Review of Client #1's habilitation record on February 5, 2009, revealed a BSP dated July 2008. Review of the BSP revealed Client #1's</p>	{W 104} Client #1's incident of "a swollen jaw" dated January 12, 2009, and diagnosed by the PCP on January 14, 2009 as "hematoma of the chin" has been re-investigated by the Incident Management Coordinator as Serious Reportable incident on 3-09-09 Refer to attachment #4	<p>In the future, the Qmrp and Incident Management Coordinator will ensure that all incidents of unknown origin are investigated as required by RCM Incident Management Policy.</p> <p>The consent form for the use of the Psychotropic medication was sent to client #1's mother on 1/09/09 eventhough the Qmrp used a different form. Refer to attachment #2 a. (#2 b is the correct form)</p> <p>In the future, the Qmrp will ensure that informed consent is obtained from client #1's surrogate decision maker (the mother) prior to the administration of his psychotropic medication.</p>

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W 124	<p>Continued From page 2</p> <p>targeted behaviors included physical aggression and resistance to medical support. Interview with the QMRP revealed Client #1's behaviors had increased since July 2009. Continued interview with the QMRP and review of a QMRP "Monthly Provider Status Report for Professional One to One Service" (for the time period of November 1, 2008 through November 30, 2008) revealed Client #1 exhibited extremely high numbers of targeted behaviors. According to the report, the client exhibited the following behaviors in the documented frequency: disrobing (19), self injury (7), crying (17), shouting (17), property destruction (3), physical aggression (6) and resistance to medical appointments (0).</p> <p>Interview with the facility's designated nurse on February 5, 2009, revealed that a psychotropic medication review was conducted on December 12, 2008. As a result of the medication review, the psychiatrist prescribed Seroquel to be added to the client's medication regimen (recommended for insomnia and for agitation).</p> <p>Interview with the QMRP on February 4, 2009, at 9:00 AM revealed that Client #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on February 5, 2009, at 1:57 PM through review of Client 1's psychological assessment dated June 24, 2008. According to the assessment, Client #1's "level of cognitive and adaptive functioning, deficits in experience, and absence of academic involvement precluded Independent advocacy. As such, the Interdisciplinary Team (IDT) assisted with decisions relative to his health, finances and placement." (Client #1) "does not demonstrate the capacity to choose the person he desires to</p>	W 124	<p>The consent form for the use of the Psychotropic medication was sent to client #1's mother on 1/09/09 even though the Qmrp used a different form. Refer to attachment #2 a. (#2 b is the correct form) In the future, the Qmrp will ensure that informed consent is obtained from client #1's surrogate decision maker (the mother) prior to the administration of his psychotropic medication.</p>

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W 124	<p>Continued From page 3</p> <p>make those decisions for him, and cannot execute a durable power of attorney." The QMRP further revealed the client did have family involvement (mother) to assist him in decision making. However, there was no evidence that the client's mother had been informed of the Seroquel and consented to its use.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.</p> <p>1. The facility failed to ensure that informed consent was obtained from Client #1's surrogate decision maker prior to the administration of sedation.</p> <p>Review of the facility's incident reports on February 4, 2009, beginning at 9:19 AM revealed the following:</p> <p>On October 21, 2008, staff reported Client #1 was seen by his Primary Care Physician (PCP) for a swollen area on his right lower leg. The client was admitted to the hospital and treated with IV antibiotics. Continued review of the report revealed the client was discharged from the hospital and seen by his PCP on November 3, 2008. According to the report, the client's PCP recommended an MRI for Client #1's right lower leg. Additionally, the PCP recommended that the client be sedated prior to the appointment.</p> <p>Interview with the facility's designated nurse and record verification on February 6, 2009, revealed Client #1 was scheduled for an MRI on November 8, 2009. Review of the client's medical record</p>	W 124	<p>The consent form for the use of the Psychotropic medication was sent to client #1's mother on 1/09/09 eventhough the Qmnp used a different form. Refer to attachment #2 a. (#2 b is the correct form)</p> <p>In the future, the Qmnp will ensure that informed consent is obtained from client #1's surrogate decision maker (the mother) prior to the administration of his psychotropic medication.</p>	
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W 124	Continued From page 4 revealed a physician's order dated November 7, 2008 for Xanax 0.5 mg thirty minutes prior to the appointment for an MRI. Continued interview with the designated nurse revealed that Client #1 was non-compliant for medical appointments and although he was sedated for the appointment on November 8, 2009, it was unsuccessful. According to the designated nurse Client #1 was scheduled for another MRI on December 12, 2008. A physician's order for Xanax 2 mg, one hour prior to the appointment was prescribed. Review of the habilitation record on February 9, 2009, revealed Client #1's mother had not signed a consent for the aforementioned sedation. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of sedation (Xanax).	W 124	The facility nurse did contact client #1's mother over the phone on 11-07-08, and obtained a verbal consent for the use of Xanax 0.5mg; however, she failed to mailed the informed consent form on time. The informed consent form was mailed on 2-09-08 Refer to attachment #3. In the future, the facility nurse will ensure that informed consent is obtained from client #1's surrogate decision maker (the mother), or legally authorized representative prior to the administration of sedation (Xanax).	
(W 149)	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the two clients (Client #1) included in the sample. The finding includes: The facility failed to implement their Incident Management Policy as evidenced below.	(W 149)		8/1/08

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(W 149)	<p>Continued From page 5</p> <p>Review of the facility's incident reports on February 4, 2009, beginning at 9:19 AM revealed an incident dated January 12, 2009, involving Client #1. According to the report, staff observed [Client #1] with a swollen jaw. Further review of the record revealed the client was seen by his Primary Care Physician (PCP) on January 14, 2009, (two days later). The PCP's consult revealed Client #1 was diagnosed with a "hematoma of the chin, unsure how it happened." Continued review of the consult revealed the PCP referred Client #1 to the radiology department of a local hospital to obtain an x-ray of his jaw.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 4, 2009, was conducted to ascertain information regarding the facility's policies and procedures for reporting/investigating incidents. The surveyor was provided a copy of the incident management policy for review. Review of the policy revealed "all incidents will be investigated." Further review of the policy revealed "all serious reportable incidents including abuse and neglect and incidents of unknown origin shall be investigated as required by internal agency policy as determined by [agency's name] Incident Management Coordinator (IMC) or in accordance with District and/or Federal regulatory requirements."</p> <p>Further interview with the QMRP on February 4, 2009, at 9:23 AM revealed that investigations were conducted by the Incident Management Coordinator (IMC). At the time of the survey, however, the facility failed to provide evidence to ensure that the aforementioned incident was investigated as specified in the facility's incident management</p>	(W 149)	<p>Client #1's incident of "a swollen jaw" dated January 12, 2009, and diagnosed by the PCP on January 14, 2009 as "hematoma of the chin" has been re-investigated by the Incident Management Coordinator as Serious Reportable incident on 3-09-09 Refer to attachment #4 In the future the Qmrp and Incident Management Coordinator will ensure that all incidents of unknown origin are investigated as required by RCM Incident Management Policy.</p> <p>Client #1's incident of "a swollen jaw" dated January 12, 2009, and diagnosed by the PCP on January 14, 2009 as "hematoma of the chin" has been re-investigated by the Incident Management Coordinator as Serious Reportable incident on 3-09-09 Refer to attachment #4 In the future the Qmrp and Incident Management Coordinator will ensure that all incidents of unknown origin are investigated as required by RCM Incident Management Policy.</p> <p>Client #1's incident of "a swollen jaw" dated January 12, 2009, and diagnosed by the PCP on January 14, 2009 as "hematoma of the chin" has been re-investigated by the Incident Management Coordinator as Serious Reportable incident on 3-09-09 Refer to attachment #4 In the future, the Qmrp and Incident Management Coordinator will ensure that all incidents of unknown origin are investigated as required by RCM Incident Management Policy.</p>

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V 149)	Continued From page 6 policy.	{W 149}		
N 154)	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on record interview and review, the facility failed to ensure that all potential injuries of unknown origin were thoroughly investigated.</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on February 4, 2009, beginning at 9:19 AM revealed an incident involving Client #1 dated January 12, 2009. According to the incident report staff documented observing Client #1 with a swollen jaw. The client was seen by his Primary Care Physician (PCP) on January 14, 2009. According to the PCP's consult, Client #1 was diagnosed with a "hematoma of the chin, unsure how it happened." Continued review of the consult revealed the PCP referred Client #1 to the radiology department of a local hospital to obtain an x-ray of his jaw.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 4, 2009, revealed that he was not certain if the incident reported on January 12, 2009, had been investigated. At the time of the survey, the facility failed to provide evidence that the aforementioned incident had been investigated.</p>	{W 154}	<p>Client #1's incident of "a swollen jaw" dated January 12, 2009, and diagnosed by the PCP on January 14, 2009 as "hematoma of the chin" has been re-investigated by the Incident Management Coordinator as Serious Reportable incident on 3-09-09. Refer to attachment #4. In the future, the Qmrp and Incident Management Coordinator will ensure that all incidents of unknown origin are investigated as required by RCM Incident Management Policy.</p>	8/1/08

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{W 154}	Continued From page 7 This is a repeat deficiency See Federal Deficiency Report dated July 17, 2008.	{W 154}	
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure that informed consent was obtained from Client #1's surrogate decision maker prior to the administration of his psychotropic medication. [See W124] 2. The QMRP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. [See W189]	{W 159}	8/18/08 The consent form for the use of the Psychotropic medication was sent to client #1's mother on 1/09/09 even though the Qmrp used a different form. Refer to attachment #2 a. (#2 b is the correct form) In the future, the Qmrp will ensure that informed consent is obtained from client #1's surrogate decision maker (the mother) prior to the administration of his psychotropic medication.
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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. This STANDARD is not met as evidenced by:	W 189	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATA SURVEY COMPLETED R 02/09/2009
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 45TH 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) COMPLETION DATE
W 189	<p>Continued From page 8</p> <p>Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Observation on February 4, 2009, at 3:51 PM revealed Client #1 entering the facility with the assistance of a direct care staff member. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on February 4, 2009, at 9:00 AM revealed Client #1 received one to one supervision and that he was visually blind. During the observation, Client #1 was noted to walk independently in front of the one to one staff person (Staff #1). At 3:53 PM, the 8:00 AM through 4:00 PM one to one staff person (Staff #2) was observed to accompany Client #1 to the kitchen area for a snack. The observation revealed the client walked with an unsteady gait as Staff #2 walked alongside of the client guiding him with her hand on the top of his head. At 5:07 PM, an administrative staff was observed holding both of Client #1's hands and walking in front of him. Interview with the QMRP on February 5, 2009, revealed the client did not have an ambulation or walking protocol. The QMRP revealed that it was the one to one staff's responsibility to be in arms length of the client. Additionally, he indicated that the staff was to use "contact guard" assistance by placing their hand on the client's back or the client could place his hand on the one to one's back. 	W 189	<p>All staff were previously trained by the PT on client #1's ambulation protocol; however, the training seemed not to be effective. The staff were retrained by the PT on the client #1's ambulation protocol and fall prevention on 2-10-09 Refer to attachment # 1 a, 1b</p> <p>Additionally all staff were trained on client monitoring on 2-10-09 Refer to attachment # 1c</p> <p>The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09 Refer to attachment #1d</p> <p>In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist</p> <p>All staff were previously trained by the PT on client #1's ambulation protocol; however, the training seemed not to be effective. The staff were retrained by the PT on the client #1's ambulation protocol and fall prevention on 2-10-09 Refer to attachment # 1 a, 1b</p> <p>Additionally all staff were trained on client monitoring on 2-10-09 Refer to attachment # 1c</p> <p>The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09 Refer to attachment #1d</p> <p>In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2009
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NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1307 45TH PLACE, SE WASHINGTON, DC 20019
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W 189 Continued From page 9

Review of Client #1's habilitation record on the aforementioned date revealed a physical therapy assessment dated October 13, 2008. According to the assessment, the physical therapist recommended to "provide the client with physical assistance for guidance during ambulation, and allow him to trail."

During the entrance conference on February 4, 2009, at 10:45 AM, interview with the facility's House Manager (HM) revealed that the staff was inserviced several times on "Supervision/Client Monitoring." Continued interview with HM and review of the facility's training record verified that the direct care staff had been trained on three different occasions, (August 16, 2008, October 3, 2008, and January 30, 2009).

At the time of the survey, however, the facility failed to ensure direct care staff were effectively trained how to properly walk with Client #1 safely and to ensure safety.

W 189

All staff were previously trained by the PT on client #1's ambulation protocol; however, the training seemed not to be effective.

The staff were retrained by the PT on the client #1's ambulation protocol and fall prevention on

2-10-09

Refer to attachment # 1 a, 1b

Additionally all staff were trained on client monitoring on

2-10-09

Refer to attachment # 1c

The Behavior Specialist has trained the staff on client #1's BSP on 2-10-09

Refer to attachment #1d

In the future, the facility will ensure that the staff follow the ambulation protocol as prescribed by the Physical Therapist