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

PRINTED: 10/02/2007
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
	09G177	A. BUILDING _____ B. WING _____	C 09/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	249 11TH STREET, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS On September 10, 2007, the Department of Health received via faxed an incident report informing this office of Client #1 death. The incident report revealed that on September 9, 2007, Client #1 was discovered in his bed unresponsive. Although attempts were made by the facility's nurse to revive the client, the Emergency Medical Services (911) was notified, and subsequently the Medical Examiner pronounced the client dead at the scene. Due to the nature of this incident, an on-site investigation was initiated on September 10. 2007. The investigative finding determined that the facility failed to met federal requirements in the conditions of Governing Body and Management, and Health Care Services. The deficiencies identified in this report were based on observations of nursing care practices, and interviews with facility direct care staff, administrative staff, medical/nursing personnel and the day program staff. The findings were also based on review of clinical and medical records as well a review of the unusual incident reports. NOTE: This report also reflects incidental deficiencies that may not be related to the client's death.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

2007 OCT 17 P 1:39

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danielle Deez
TITLE: Chief Operating Officer
(X6) DATE: 10/17/07

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 102	Continued From page 1	W 102		
	This CONDITION is not met as evidenced by: The governing body failed to maintain general operating direction over the facility to ensure safety and to prevent neglect in accordance with clients assessed needs (See W104);			
	The results of these systemic practices revealed that the facility's Governing Body failed to adequately govern the facility in a manner that would ensure its clients' are provide with care and treatment according to the agency's policy and procedures.			
W 104	483.410(a)(1) GOVERNING BODY	W 104		
	The governing body must exercise general policy, budget, and operating direction over the facility.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provided general operating direction over the facility as described in the following:			
	1. The Governing Body failed to have an effective system of monitoring nursing practices, ensure ongoing nursing training and ensure nurse followed agency nursing protocol in accordance with the agency's policy and procedures. [See W331, W322, W362, W368, W369, W381, W382]		All of the agency's nurses were trained by the RN supervisor on the best nursing practices. The nurses will follow the agency's nursing protocol in accordance with the agency's policies and procedures.	10-17-07
	2. The Governing Body failed to have an effective system effective system of managing medications to include appropriate accounting and storage of medication as detailed in the agencies policy and procedures. [See W331,		The RN has trained the LPN on the medication monitoring, documentation, storage and accountability. The RN has developped a system to monitor the medication. The LPN will monitor the medication pass on the weekly basis for three consecutive months. The RN will monitor the medication pass on a monthly basis for three consecutive months.	

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W 104	Continued From page 2 W365, W367, W377,] 3. The Governing Body failed to have an effective system to ensure that the facility's medication nurse followed infection control procedures in accordance with the agency's policies and procedures. [See W377]	W 104	In the future the agency nursing dept.will ensure that the medications are stored as per agency policies and procedures, and that there is a system for the medication accountability in place. Refer to attachment #1 The former medication nurse was terminated. The current medication nurse was trained on the infection control during the medication pass.	10-16-07
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure and encourage two of the four clients residing in the facility an opportunity to exercise their rights to privacy. (Client #2 and #3) The finding includes: The nurse failed to ensure each Client #2 and Client #3's privacy as evidenced below: During observation the medication pass on September 11, 2007 at approximately 8: 24 PM the medication nurse went into Client #2 and Client #3's bedroom to administer Client #2's treatment to his toe nails. The nurse turn on the overhead light and awakens Client #3. Client #2 was laying in his bed awake. The nurse administered topical treatment to Client #2 in the presence of Client #3. There was no attempt by the nurse to shield Client #3 during this treatment. At no time prior to the nurse administering Client #2's treatment was the client	W 130	In the future, the nursing department will ensure that the infection control is implemented during the medication pass. Refer to attachment #2 It is the policy of this agency that privacy should be respected during the medication pass. The medication should be given to the individual away from the other consumers. Each facility has a designated medication area. All of the agency nurses have been trained on the nursing best practices. Refer to attachment #3 In the future the agency will ensure that privacy is given during the medication pass as per the	10-16-07

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W 130	Continued From page 3 encourage to go to the medication room to allow the client privacy. Finally, the nurse was observed to leave the bedroom without turning off the overhead light. Client #3 had to get out of his bed and turned off the overhead light.	W 130	The mediactaion nurse was terminated by not implementing the nursing best practices. All nurses were inserviced on best practices. In the future, the nursing team will ensure that privacy is given to client # 3 whenever he is in his bedroom. Refer to attachment #3	10-16-07
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 interviews and record verification, the facility failed to establish and/or implement policies that ensured the health and safety of one of the six clients (Client #1) that resided in the facility. The findings include: The facility failed to ensure policies and procedures had been developed and/or implemented to ensure client's safety and to prevent neglect as evidenced below: The finding includes: The medication nurse failed to document a medication error and destroy medication as outlined in the agency's nursing policy and procedures as evidenced below: 1. During the medication administration on September 12, 2007 at approximately 6:22 PM,	W 149		

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W 149	Continued From page 4 The medication nurse was observed to punch Client #4 dosage of Risperdal 1 mg form the bubble pack in error. The nurse placed cup with the pill on the shelf of the computer table. Through-out the remainder of the medication pass administration the nurse was observed to leave the medication room on several occasions without securing this dosage of medication. At no time during or after the medication pass did the medication nurse document her error and/or reconcile the medication administration records to account for this medication. Review of the agency's Department of Nursing policy and procedure revealed that license Nursing staff medication error classification outlined the following: Nursing staff are expected to document the error in medication administration in the MAR and to properly dispose of the medication by: Crush and melt completely and flush down the drain. The nurse failed to communicate the error to the designated nurse who was on site, to properly secure this pill for the safety from the the client's. Client #3, Client #4, direct care staff and the surveyor were in the area when the medication was unsecured. Note: It should be noted that the nurse did not remove the unsecured dosage of Risperdal from the computer table and was observed to prepare to leave the facility. The surveyor alerted the nurse just prior to her departure that she had left the pill unsecured.	W 149	It is this agency policy that all medication errors are documented on the MAR, and that medications are properly disposed. Additionally the error must be communicated to the designated nurse and the RN. The medication nurse failed to implement the policy regarding the medication error, and consequently was terminated. All agency nurses were trained. The RN will train the nurses on the quartety basis. In the future the agency's nursing department will ensure that medications errors are handled according to the policies and procedures. Refer to attachment #4	10-16-07

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W 149	Continued From page 5	W 149		
	2. The designated nurse failed to destroy medications in accordance with the agency's policy and procedure as evidenced below:		The designated nurse and medication nurse will be trained by the RN on a quarterly basis; this training will focus on on the policies and procedures regarding the nurses best practices.	
	On September 12, 2007 at 8:15 PM, interview with the designated nurse and a review of the medication administration records revealed that Client #4's Risperdal 2 mg medication was started on September 4, 2007. The Designated nurse stated" I punched out the 4 dosages (9/1 through 9/4) to correspond with the start date of the medication. When asked how he destroyed the medication, he commented "I threw them away". A request was made to see the documentation on file for the medication disposal however, the nurse was unable to provide evidence of the four missing pills.		In the future the designated nurse will ensure that the medications are disposed according to the agency's policies and procedures, and that a proper documentation is availble to show evidence.	
	3. The medication nurse failed to administer Client #3 prescribed topical treatment medication in accordance with the agency's policy and procedure as evidenced below:		It is the policy of this agency that all medications are administrated as prescribed. The current medication nurse was inserviced by the designated nurse.	10-16-07
	During the medication administration on September 12, 2007 at 7:25 PM, the nurse failed to administer Client #3's Ketoconazole Cream 2% for affected skin area, Minerin Cream for moisturizing and Desonide 0.05% Cream for the face as prescribed by the primary care physician.		The RN will train the nurses on a quartery basis or as needed. The designated nurse will review, and monitor the medication administartion on a weekly basis for 3 consecutive months. The RN will monitor the medication pass on a monthly basis for three consecutive months. Refer to attachment #1	10-16-07
	Interview the medication nurse revealed that she thought she was finished with the medication pass. Client #3 was to have receive these topical treatments during the evening medication pass.		In the future the agency's nursing department will ensure that the medications are administrated as prescribed.	
	4. The facility's nursing staff failed to provide preventative care in accordance with Client #1's medical condition. (See W322)		According to the agency's policies and procedures the nurse needs to document, and report any significant event related to the individual's health and safety. The medication nurse was	

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W 149	Continued From page 6 5. The facility's nursing staff failed to ensure infection control policy and procedures were implemented. (See W377) 6. The facility's direct care staff follow the agency's policy and procedures of notification of medical personnel. (See W192)	W 149	In the future the nursing department will ensure that the nurses will report significant event related to the individual's health and safety. Refer to W 104 (3) P.3 All staff were trained on the signs and symptoms on illness on March 2, 2007. All staff were retrained on signs and symptoms of illness and proper notification of the medical personnel.	10-16-07 10-09-07
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's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment. The finding includes: The QMRP failed to ensure that staff were trained to implementation the agencies policies and procedures of notification of medical personnel for Client #1. [See W192]	W 159	In the future the the agency will ensure that the staff notify the medical personnel if the there a change in the individual's health status. Refer to attachment #5	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to	W 192		

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	Continued From page 7 implementation its policies and procedures of notification of medical personnel for one of the clients residing in the facility. (Client #1) The findings include: 1. The facility failed to ensure direct care staff implemented the agency's policies and procedures to ensure direct care staff notified medical professionals as evidenced below: On September 12, 2007 at 10:10 AM, interview with Staff #1 revealed that on September 8, 2007, during the 3:00 PM - 11:00 PM shift, the staff noted changes in Client #1 health status as described below: Upon Staff #1's arrived for duty between 6:00 - 6:30 PM Client #1 was observed to be his "normal self" and was observed sitting in the medication room talking with the medication nurse. At approximately 7:30 PM (one hour later), Staff #1 observed Client #1's to come down the stairwell and walk over to dinner table very slowly. Reportedly this was not usually behavior during meal time. Staff #1 explained that the client "loved to eat and this was not his normal behavior." Staff #1 stated that Client #1 set down at the table and took one bit of his dinner. He then immediately took the bite of food from his mouth and placed the un chewed food on the dinner table. The staff commented with great intensity to the surveyor, "He was sick!" The client left the table without eating his meal. Staff #1 did not notify nursing or management staff of the client's refusal to eat. According to an interview with the Residential	W 192	All staff were trained on the signs and symptoms on illness on March 2, 2007. All staff were retrained on signs and symptoms of illness and proper notification of the medical personnel. In the future the the agency will ensure that the staff notify the medical personnel in the there is a change in the individual's health status. Refer to attach #5	10-09-07

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W 192	Continued From page 8 Director on 9/12/07 at 11:40 AM and training record verification, Staff #1 was trained in signs and symptom of illness on March 2, 2007.	W 192		
	2. At approximately, 9:00 PM on 9/8/07, Staff #1 went into Client #1's bedroom and observed him sitting on the side of his bed quitely rocking back and forth. She commented, "He was sweating very heavily." Staff #1 asked the client to take a bath and he refused. At that time the staff gave the client 8 ounce of water and encouraged him to return to bed. Staff #1 reported that Client #1 had been to a community hospital's emergency room three days ago (9/5/07) and was observed to have similar symptoms at that time. Interview with the staff and the review of records failed to provide evidence that the nursing or management staff had been notify of the client's health status.		Refer to W 192 P. 8	10-09-07
	On September 11, 2007 a note was observed posted on the wall in the medication room that read: "TO: ALL RCM STAFF - Please notify the nurse if any resident is not feeling well, so that he/she may be evaluated and treated."		Refer to W 192 P. 8	10-09-07
	Review of the agency training log revealed that on March 2, 2007 all staff were trained on the signs and symptoms of illness. Review of the agenda and signature sheet revealed that Staff #1 was listed as a participant in that training.		Refer to W 192 P. 8	10-09-07
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The facility failed to provide adequate Health Care	W 318		

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W 318	Continued From page 9 Services as evidence in the deficiencies cited throughout this report. Based on observation, interviews, and record reviewed, the facility failed to establish systems to failed to ensure health services were provided to meet the needs of the clients [See W322]; the facility failed to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [See W331]; the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly [See W362]; the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained [W365]; the facility failed to have an organized system for drug administration [W367]; the facility failed to ensure that medications were administered in accordance with physician's orders [W368]; the facility failed to ensure that medication nurse administered prescribed medication with out error [W369]; the facility failed to ensure that drug administration errors were recorded [W375]; the facility failed to ensure medication were stored under proper conditions of sanitation [W377]; the facility failed to store drugs under proper conditions of security [W381]; the facility failed to keep all drugs and biologicals locked securely when not being prepared for administration [W382]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	Refer to W 322 (1,2,3) P. 11&12 Refer to W 322 (1,2) P. 11 The RN has trained the LPN and medication nurse on the medication monitoring, documentation and the importance of taking the vital signs and weight. Refer to attachment #6 (a) In the future the nursing supervisor will ensure that the physicians orders are implemented as prescribed. All nurses were trained on the medication monitoring, documentation and accountability. In the future the agency nursing departmant will ensure that the medications are are administered according to the agency's policy and procedures.I Refer to attachment #1 The facility nurse as well as all of the agency's nurses were trained on the documentation. A release of responsibility form will be completed accurately each time the individual leaves the facility.	10-16-07 10-16-07 10-16-07 10-16-07 10-16-07
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322		

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W 322	Continued From page 10	W 322		
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care. The finding includes: The facility failed to ensure preventive care was provided for Client #1 prior to his death in accordance with the agency's policy and procedures as evidenced below: 1. Interview with the medication nurse on 9/10/07 at 5:40 PM revealed that she assessed Client #1 on 9/8/07 and noted that both his legs were "swollen and tight". Although the nursing progress notes dated 9/8/07 verified her assessment, the records failed to indicate that the client's swollen legs were reported to the Primary Care Physician (PCP) or the Registered Nurse.		According to the agency's policies and procedures the nurse needs to document, and report any significant event related to the individual's health and safety. The medication nurse was terminated for failing to following the policies and procedures. All nurses were trained on the nursing best practices. In the future the nursing department will ensure that the nurses will report significant event related to the individual's health and safety. All nurses have been inserviced on the nursing best practices.	10-16-07
	2. Interview with the day program nurse on 9/11/07 at approximately 2:15 PM revealed that the nurse spoke with Client #1's PCP via a telephone contact on 9/4/07 to report that Client #1 was not feeling well. According to the nurse the doctor asked the nurse was the client's legs swollen. The nurse informed the PCP that the Client's legs were not swollen at that time.		Refer to W 322 (1) P. 11	10-16-07
	3. A telephone interview with the primary care physician on 9/19/07 at 11:20 AM revealed that the physician was aware of the Client's swollen legs. She indicated that the Client may have been exhibiting signs of heart disease.		Refer to W 322 (1,2) P. 11	10-16-07
	When questioned about the facility's emergency			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G177	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C. 09/12/2007
PROVIDER OR SUPPLIER: ROOM OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 11TH STREET, 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 322	Continued From page 11 notification protocol, The PCP was knowledgeable and stated that the policy required the designated nurse to contact her directly during any health related concern especially during a medical emergency. Review of the agency's notification of medical personnel policy and procedures for nursing assessments outlines that the nursing staff were to "communicate any concerns to the Medical Director, QMRP and Executive Program Director immediately". The nurse failed to communicate to her supervisor or the Medical Director that Client #1's condition had change after her assessment on 9/8/07.	W 322	Refer to W 322 (1,2) P. 11	10-16-07
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 failed to provide nursing services in accordance with the needs of the clients residing in this facility. (Clients #3). The findings include: Interview and record review of Client #3's medical records on September 11, 2007 at approximately 1:00 PM revealed that the client has physician orders for vital signs and weight were to be taken at 7:00 PM monthly and document in the MAR. Further review of the MAR revealed that 9/11/07 the nurse was to have taken the vital sign during the medication pass. Additionally, the nurse had not documented any vital signs from the period of May 2007 to September 2007 during the PM	W 331	The RN has trained the LPN and medication nurse on the medication monitoring, documentation and the importance of taking the vital signs and weight. In the future the nursing supervisor will ensure that the physicians orders are implemented as prescribed. Refer to attachment #6 (a)	10-16-07

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	09G177		C 09/12/2007

NAME OF PROVIDER OR SUPPLIER: R C M OF WASHINGTON

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W 331	Continued From page 12 medication pass as ordered. According to the review of the weight charts in the MAR the last documentation Client #3's weight was in April 2007.	W 331		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly, for one of the four client residing in the facility. (Client #1) The finding includes: Interview with the nurse and review of the medical records revealed that Client #1 last pharmacological review occurred on March 19. 2007. According to the nurse, the next review was to have occurred in June, 2007. At the time of this death investigation, review of the drug regimen review sheet failed to evidence that the Pharmacist reviewed Client #1 medications for the next quarter June 2007 had not occurred timely as required by this regulations.	W 362	The last pharmacy review for client #1 was completed on 6-25-07. Refer to attachment #7	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by:	W 365		

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I 000	INITIAL COMMENTS On September 10, 2007, this office was notified via fax incident report regarding the death of Client #1 that occurred on September 9, 2007 in the group home in which he resided. An on-site investigation was initiated on September 10, 2007 through September 12, 2007. The licensure deficiencies cited in this report were based on observation of the medication nurse, interviews with facility direct care staff, management and day program staff, review of medical records and review of habilitation records as well a review of the unusual incident reports.	I 000		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The finding includes: Review of the personnel files on September 12, 2007 at 1:00 PM revealed the GHMRP failed to provide current job descriptions for the PM Medication Nurse and the Designated Nurse assigned to this facility.	I 202	The Pm medication nurse was terminated The Designated nurse's job description is currently on file. Refer to attachment #11 In the future tha provider will ensure that all of employees job descriptiona are on file.	9-25-07 9-25-07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and	I 206		

Health Regulation Administration

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

STATE FORM 6899 6V2111 If continuation sheet 1 of 5

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I 206	Continued From page 1 annually thereafter, shall provide a physician ' s 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. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 12, 2007 at 1:10 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for Staff #1.	I 206	Staff # 1 health certificate was on file at the corporate office; however she was terminated on 10-03-07. Refer to attachment #12 In the future tha agency will ensure that all of the staff personal files are present in the facility, and available upon request.	9-25-07
I 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:	I 222		

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I 222	Continued From page 2 1. The facility failed to ensure direct care staff implemented the agency's policies and procedures to ensure direct care staff notified medical professionals as evidenced below: On September 12, 2007 at 10:10 AM, interview with Staff #1 revealed that on September 8, 2007, during the 3:00 PM - 11:00 PM shift, the staff noted changes in Client #1 health status as described below: Upon Staff #1's arrived for duty between 6:00 - 6:30 PM Client #1 was observed to be his "normal self" and was observed sitting in the medication room talking with the medication nurse. At approximately 7:30 PM (one hour later), Staff #1 observed Client #1's to come down the stairwell and walk over to dinner table very slowly. Reportedly this was not usually behavior during meal time. Staff #1 explained that the client "loved to eat and this was not his normal behavior." Staff #1 stated that Client #1 set down at the table and took one bit of his dinner. He then immediately took the bite of food from his mouth and placed the un chewed food on the dinner table. The staff commented with great intensity to the surveyor, "He was sick!" The client left the table without eating his meal. Staff #1 did not notify nursing or management staff of the client's refusal to eat. According to an interview with the Residential Director on 9/12/07 at 11:40 AM and training record verification, Staff #1 was trained in signs and symptom of illness on March 2, 2007. 2. At approximately, 8:00 PM on 9/8/07, Staff #1	I 222	All staff were trained on the signs and symptoms of illness on March 2, 2007. All staff were retrained by the designated nurse on the signs and sypmtoms of illness, and proper notification when the client's health status changes. Refer to attachment # 5 In the future tha agency will ensure that the staff notify the nursing or management when the client health status changes.	10-09-07

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I 222	Continued From page 3	I 222		
	went into Client #1's bedroom and observed him sitting on the side of his bed quitely rocking back and forth. She commented, "He was sweating very heavily." Staff #1 asked the client to take a bath and he refused. At that time the staff gave the client 8 ounce of water and encouraged him to return to bed. Staff #1 reported that Client #1 had been to a community hospital's emergency room three days ago (9/5/07) and was observed to have similar symptoms at that time. Interview with the staff and the review of records failed to provide evidence that the nursing or management staff had been notify of the client's health status.			
	On September 11, 2007 a note was observed posted on the wall in the medication room that read: "TO: ALL RCM STAFF - Please notify the nurse if any resident is not feeling well, so that he/she may be evaluated and treated."			
	Review of the agency training log revealed that on March 2, 2007 all staff were trained on the signs and symptoms of illness. Review of the agenda and signature sheet revealed that Staff #1 was listed as a participant in that training.		All staff were trained on the signs and symptoms of illness on March 2, 2007. All staff were retrained by the designated nurse on the signs and sypmtoms of illness, and proper notification when the client's health status changes. Refer to attachment # 5	10-09-07
I 227	3510.5(d) STAFF TRAINING	I 227	In the future tha agency will ensure that the staff notify the nursing or management when the client health status changes.	
	Each training program shall include, but not be limited to, the following:			
	(c) Infection control for staff and residents;			
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file training for the medication nurse in infection control.		Refer to W 149 P.7	10-16-07
	The findings include:			

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I 227	Continued From page 4 See Federal Deficiency Report Citation W377	I 227		
I 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on observation , interview and record review the GHMRP failed to ensure that the staff and nursing personnel followed the agency policies and procedures on emergencies. The finding include: See Federal Deficiency Report Citation W104, W318	I 370	Refer to W 104 P.3 Refer to W 318 (1,2,3) P.11	10-16-07 10-16-07

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W 365	Continued From page 13 Based on staff interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for two of the four clients that are entrusted to the facility. (Client #3 and #4) The findings include: 1. The facility failed to ensure its system for documentation of Client #3's medication administration in accordance with the agency's policy and procedures as evidence by the following: Review of Client #3's Medication Administration Record (MAR) after the medication pass observation on September 11, 2007 at approximately 6:15 PM revealed that on 9/8/07 the client's noon dosage of Hydroxyzine 25 mg had not been signed as being administered. Interview with the designated nurse on 9/12/07 at approximately 11:45 AM revealed that the weekend nurse failed to sign that the medication was administered. Review of the medication bubble packed evidence no pill in the slot designated for the noon dosage for 9/8/07. 2. The facility failed to ensure its system for documentation of Client #4's medication administration in accordance with the agency's policy and procedures as evidence by the following: Review of Client #4's Medication Administration Record (MAR) after the medication pass observation on September 11, 2007 at approximately 6:15 PM revealed that on 9/8/07	W 365	All nurses were trained on the medication monitoring, documentation and accountability. In the future the agency nursing department will ensure that the medications are administered according to the agency's policy and procedures.l Refer to attachment #6 (b)	10-16-07
			The facility nurse as well as all of the agency's nurses were trained on the documentation. A release of responsibility form will be completed accurately each time the individual is on leave.	10-16-07

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W 365	Continued From page 14 the client's noon dosage of Buspirone 10 mg had not been signed as being administered. Interview with the designated nurse on 9/12/07 at approximately 11:45 AM revealed that the weekend nurse failed to sign that the medication was administered. Review of the medication bubble packed for that date evidence no pill in the slot designated for the noon dosage for 9/8/07. Review of the medical record indicated a Leave of absence form for 9/8/07, however staff indicated that Client #4's mother did not arrive at the facility to pick him up until after 5:00 PM in the evening. Additionally, the nurse failed to sign, date and place the time on the release of responsibility form for Client #4's mother who was given his medication to administered during his home visit. 3. There was no evidence that the facility had an organized system for drug administration utilizing the bubble pack to ensure accuracy and accountability of medications in accordance with the agency's policy and procedures. Observation of the medication pass on September 11, 2007 at approximately 6:15 PM revealed that the medication nurse punched Client #4's Risperdal 1 mg medication from the bubble pack into a paper cup and immediately afterwards commented, "This is the wrong medication". She was then observed to place the cup with the pill on the side of the computer table. The nurse was observed to remove a second bubble pack of pills from the medication closet. The nurse punch out the second pill and then administered the medication to Client #4. Review of the second bubble packaging revealed that this medication was Risperdal 2 mg.	W 365	Refer to W 365 P. (1) P. All the agency nurses were trained on the medication administration utilizing the bubble pack to ensure the accuracy, and accountability of medications. All discontinued medications will be removed from the cabinet assoon as possible. Refer to attachment #8 In the future the agency's nursing department will ensure that the drug administration using the bubble pack is utilized effectively, and that the discontinued meds are removed promply.	10-16-07 10-16-07

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W 365	Continued From page 15	W 365		
	Interview with the Designated nurse revealed that that the nurse was not to have punched the Risperdal 1 mg dosage and commented,"This bubble package had been removed from the medication closet."			
	Review of the Medication Administration records revealed the Risperdal 1 mg dosage had been discontinued on 9/5/07, however, the medication dosages for 9/5, 9/6, 9/7, 9/8 9/9 and 9/10 were missing from the bubble packaging. Further review of the MAR did not evidence an accurate accounting for this missing pills.		Refer to W 365 P. 15 (3)	10-16-07
	4. Observation of the medication pass on September 11, 2007 at approximately 5:15 PM revealed that the medication nurse punched Client #4's Risperdal 2 mg medication from the bubble pack.			
	Interview with the Designated nurse revealed that this dosage of medication was started on 9/5/07. The Designated Nurse stated "I punched out the dosage for 9/1, 9/2, 9/3 and 9/4 so that the start date on the bubble packaging would correspond with the physician ordered start date." The surveyor requested to see the agency Drug form used in documenting the disposal of the four dosages of Risperdal. The Designated Nurse was unable to produce any documentation accounting/reconciling the missing Risperdal medication.		Refer to W 365 P. 15 (3)	10-16-07
	Review of the MAR and the nurses notes on 9/12/07 failed to evidence that the nurse had document the disposal of the four missing Risperdal pills.			
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 16 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders for one of clients who resided in the facility. (Clients #3) The finding includes: The facility's medication nurse failed administer medications prescribed by the primary care physician in accordance with the agency's policy and procedure. The finding includes: During Client #3's medication administration on September 12, 2007 at approximately 7:52 PM, The medication nurse was observed to remove from the medication cabinet four topical medications. Review of the physician's order dated August 1, 2007 revealed that Client #3 was to have received the following topical treatment during the evening medication pass: 1) Erythromycin 2% Solution Apply to affected area of beard BID 2) Laprox Shampoo to scalp 2 X week 3) Lachydron 12% Lotion Apply to scaly areas of the leg BID 4) Desonide 0.5% cream Apply to affected area	W 368	Refer to W 149 (3) P. 6 Refer to attachment #6	10-16-07

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W 368	Continued From page 17 of face BID However only the (1) Erythromycin 2% cream to the ear and neck and the (2) Amlactin 12 % lotion was applied to both lege during the medication pass. After applying this medication, she stated "I'm finished and placed all 4 medication back in the medication closet. Review of the MAR for September 2007, however, revealed that Client #3's topical treatment medications for administration were as follows: 1) Ketoconazole Cream 2% apply to affected area twice daily 2) Minerin Cream apply daily to skin for moisturizer 3) Desonide 0.5% Cream Apply to dry area of face every day in PM The medication listed on the physician order , the MAR and the medication administered by the nurse did not coincide. 1. The medication nurse administered the Amlactin 12% solution during the med pass, however this medication was not list on the physician order. 2. Client #3's Ketoconazole Cream 2% was to have been administered twice daily, however review of the MAR revealed that for the month of September indicated that this medication was not being administered consistently and was not administered during the medication pass as ordered. 3. The Minerin Cream and the Desonide Cream which was prescribed for the PM had not been administered either during the medication pass as ordered.	W 368	Refer to W 149 (3) P. 6 Refer attachment #6 (b)	10-16-07
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369		

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W 369	Continued From page 18 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medication nurse administered prescribed medication with out error, for one of the four client's residing in the facility. (Client #3) The finding includes: During Client #3's medication administration on September 12, 2007 at approximately 7:52 PM, The medication nurse was observed to remove from the medication cabinet four topical medications. Review of the physician's order dated August 1, 2007 revealed that Client #3 was to have received the following topical treatment during the evening medication pass: 1) Erythromycin 2% Solution Apply to affected area of beard BID 2) Laprox Shampoo to scalp 2 X week 3) Lachydron 12% Lotion Apply to scaly areas of the leg BID 4) Desonide 0.5% cream Apply to affected area of face BID However only the (1) Erythromycin 2% cream to the ear and neck and the (2) Amlactin 12 % lotion was applied to both lege during the medication pass. After applying this medication, she stated "I'm finished and placed all 4 medication back in the medication closet.	W 369	Refer to W 149 (3) P. 6 Refer to attachment #6 (b)	10-16-07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G177	A. BUILDING _____ B. WING _____	C 09/12/2007

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D[illegible]M OF WASHINGTON	249 11TH STREET, SE WASHINGTON, DC 20019

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W 369	Continued From page 19 Review of the MAR for September 2007, however, revealed that Client #3's topical treatment medications for administration were as follows: 1) Ketoconazole Cream 2% apply to affected area twice daily 2) Minerin Cream apply daily to skin for moisturizer 3) Desonide 0.5% Cream Apply to dry area of face every day in PM The medication listed on the physician order, the MAR and the medication administered by the nurse did not coincide. 1. The medication nurse administered the Amlactin 12% solution during the med pass, however this medication was not list on the physician order. 2. Client #3's Ketoconazole Cream 2% was to have been administered twice daily, however review of the MAR revealed that for the month of September indicated that this medication was not being administered consistently and was not administered during the medication pass as ordered. 3. The Minerin Cream and the Desonide Cream which was prescribed for the PM had not been administered either during the medication pass as ordered.	W 369	Refer to W 149 (3) P. 6 Refer to attachment #6 (b)	10-16-07
W 377	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of sanitation. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure medication were stored under	W 377		

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W 377	Continued From page 20 proper conditions of sanitation. The finding includes: The facility's medication nurse failed to ensure safe infection control practices during the medication administration in accordance with the agency's infection control policy and procedures as evidenced below: 1. On September 11, 2007 at approximately 6:22 PM, the medication nurse was observed to reach in the medication closet and remove Client #4 Glycolax and place scoop in his water. The nurse was observed to search for the top for the mixture, however she was not able to find the top to secure the medication from contamination. The nurse was then observed to place a medication cup loosely on top of the bottle and put the mixture back into the medication closet. There was no evidence that this medication was seal to ensure its continued potency.	W 377	It is important to note that the facility medication nurse was terminated for not using the nursing best practices. All of agency's nurses have been inserviced on the infection control according to the policy and procedures. Refer to attachment # 2 In the future the agnency's nursing department will ennsure that the infection control procedures are implemented during the medication pass.	10-16-07
	2. During the medication pass on September 11, 2007 at approximately 6:55 PM the medication nurse was observed to administer Client #3's medication in his medication cup. After the client to had taken his medication he passed the cup he used to the nurse. The nurse was observed place the dirty medicine cup onto the stack of unused/clean medicine cups. The nurse realized that she had contaminating the medicine cups, but only removed the top cup she place on the stack and threw it away. The falled to discard the other contaminated medicine cups but placed them back in the medication closet.		Refer to W 149 (1) P. 4,5	10-16-07
W 381	483.460(I)(1) DRUG STORAGE AND RECORDKEEPING	W 381		

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W 381	Continued From page 21 The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security. The finding includes: The facility failed to ensure that each client's medications and topical treatment medication were secured in accordance with the agency's policy and procedures as evidence by the following: 1. During the medication administration on September 12, 2007 at approximately 6:22 PM, The medication nurse was observed to leave the medication cabinet open and unlocked to go into the bathroom. Client #4 and the surveyor were in the area when the medication cabinet was unsecured.	W 381	Currently all medications are kept on a locked cabined. All nurses were trained on the medication storage. Refer to attachment #9 Inthe future the nursing department will ensure that the medications are stored according to the agency's policies and procedures.	10-16-07
	2. During the medication administration on September 12, 2007 at approximately 6:22 PM, The medication nurse was observed to leave several topical medication for Client #3's treatment on the computer table unsecured and left the room for several minutes. Client #3 and the surveyor were in the area when the medication cabinet was unsecured.		Currently all medications are kept on a locked cabined. All nurses were trained on the medication storage. Refer to attachment #9 In the future the nursing department will ensure that the medications are stored according to the agency's policies and procedures.	10-16-07
	3. During the medication administration on September 12, 2007 at approximately 6:22 PM, The medication nurse was observed to pour Client #4 dosage of Risperdal 1 mg pill in error			

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W 381	Continued From page 22 and stated This is the wrong medication". The nurse then place the paper cup with the pill on the shelf of the computer table. Through-out the two and half medication pass the nurse was observed to leave the medication room on several occasions without securing this dosage of medication. At no time during or after the medication pass did the medication nurse return to the computer table to secure this pill for the safety of the client and others. Client #3, Client #4, direct care staff and the surveyor were in the area when the medication was unsecured. Note: It should be noted that the nurse prepared to leave the facility and the surveyor alerted the nurse just prior to her departure that she had left medication in the medication room on the computer table unsecured.	W 381	Refer to W 381 (1,2) P 22	10-16-07
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, the facility failed to keep all drugs and biologicals locked securely when not being prepared for administration. The findings include: On September 11, 2007 at approximately 8:15 the medication nurse was observed to leave Client #3's topical medication for his skin treatment on the computer table unsupervised and left the room and went into the bathroom. The nurse also left the medication cabinet open	W 382	Refer to W 381 (1,2) P 22	10-16-07

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W 382	Continued From page 23 at approximately 8:30 and went into the client Client #2's bedroom. Additionally, Client #4's medication in which she had punched in error was left on the computer shelf unsupervised and was not destroy as required by the agency's policy and procedures. There was no evidence that the medication nurse ensured the all the client's medications were consistently and properly secured.	W 382	Refer to W 381 (1,2) P 22	10-16-07

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R 000	INITIAL COMMENTS On September 10, 2007, this office was notified via fax incident report regarding the death of Client #1 that occurred on September 9, 2007 in the group home in which he resided. An on-site investigation was initiated on September 10, 2007 - September 12, 2007. The licensure deficiencies cited in this report were based on observation of the medication nurse, interviews with facility direct care staff, management and day program staff, review of medical records and review of habilitation records as well a review of the unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT 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 the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any 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. The finding includes: Review of the personnel records on September 12 2007 at 1:00 PM revealed that the GHMRP failed to provide evidence that ensured criminal	R 125		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Operating Officer — (X6) DATE: 10/17/07

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R 125	Continued From page 1 background checks were on file and disclosed for Staff #2 seven year history of all the jurisdictions where the employee resided and has been employed.	R 125	The background check for staff #2 was on file at the corporate office, not a the facility. Refer to attachment # 10 In the future the agency will ensure that all personal records are on files, and available upon request.	9-25-07