

ADMINISTRATIVE OFFICE
900 Second Street, NE – Suite 8
Washington, DC 20002
(202) 789-1930 Phone



Date: 4-10-14

To: Sharon Mebane, Program Manager
Department Of Health
899 N. Capitol Street, NE
2th Floor
Washington DC. 20002

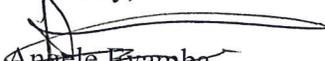
RE: Plan of action for the deficiencies at 2420-T Street SE

Dear Mrs. Mebane,

Please find attached the plan of correction for the deficiencies found at the above mentioned location following the monitoring visit conducted by the Department Of Health on 3-19-2014 (Survey ending 3-21-14).

Please do not hesitate to contact me if you have any questions or concerns.
(202) 468-0625
Or Danielle Darby at (240) 483-7274

Sincerely,


Angele Eyamba,
Program Director, ICF/ID

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

PRINTED: 03/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2014
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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 March 19, 2014 through March 21, 2014. A sample of three clients was selected from a population of three females with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. - Human Rights Committee - HRC - Milligrams - mg - Cubic centimeter - cc - Program Coordinator - PC - Individual Support Plan - ISP - Direct Support Professional - DSP - Day Program Staff - DPS - Group Home for Individuals with Intellectual Disabilities - GHIID - Registered Nurse - RN - Qualified Intellectual Disabilities Professional - QIDP - Licensed Practical Nurse - LPN - Milliliters - ml - Day Program Case Manager - DPCM	W 000		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.	W 112		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **CSD** (X6) DATE **4/10/14**

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 112	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to put in place safeguards to ensure each client's information was limited to designated individuals by law, for two of three clients in the sample. (Clients #1, #3, #4, #5 and #6)</p> <p>The finding includes:</p> <p>On March 19, 2014, at 2:15 p.m., there were two documents observed posted openly on the kitchen cabinet doors. Review of the first document revealed that it included Client #1's full name and the client's meal time protocol, which included the client's dietary information and adaptive feeding equipment. At 2:16 p.m., a second document that described Clients #4, #5 and #6 adaptive equipment was observed posted openly of the refrigerator. On March 20, 2014, at 3:50 p.m., a third document openly posted in the living room next to the television revealed that Client #3's was on 1500 cc daily fluid restriction.</p> <p>Observations on March 20, 2014, at approximately 9:50 a.m., and March 21, 2014, at 10:25 a.m., respectively, revealed there were two staff not employed by the facility standing in the living room/kitchen area near the clients' personal information.</p> <p>On March 21, 2014, at approximately 11:40 a.m., the posting was brought to the attention of the QIDP during the inspection of the facility. The QIDP immediately removed the information from the kitchen cabinets and off of the wall in the living room.</p> <p>At the time of the survey, the facility failed to ensure the confidentiality of the clients' personal</p>	W 112	<p>It is RCM's policy that all of the individuals' information are kept in strick confidentiality. All staff were inserviced by the facility QIDP on confidentiality on 3-24-14 Refer to attachment #1 in the future, the facility's management will ensure that the individuals' record are kept in the conspicuous place, and away from people who do not directly serve the individuals.</p> <p>It is RCM's policy that all of the individuals' information are kept in strick confidentiality. ll staff were inserviced by the facility QID on confidentiality on 3-24-14 Refer to attachment #1 in the future, the facility's management will ensure that the individuals' record are kept in the conspicuous place, and away from people who do not directly serve the individuals.</p>	3-24-14	

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W 112	Continued From page 2 information.	W 112			
W 120	<p>It should be noted that based on interview with the DSP #1, the two staff observed walking through the facility and standing near the clients' personal information were employed by the facility's day program that was located in the basement of the facility.</p> <p>483 410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services utilized infection control procedures during lunch time, for one of three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On March 19, 2014, at 12:20 p.m., DPS #1 was observed to place a blue hand clapper into Client #3's left hand while seated at the round table inside the classroom. Several minutes earlier, the same hand clapper was observed lying on top of Client #3's lap tray. At approximately 12:25 p.m., DPS #1 verbally prompted Client #3 to reach inside a small basket, retrieve the round chips inside the basket and give the chips to him. The client was observed to reach into the basket, retrieve the chips and hand the chips to DPS #1 three times. At approximately 12:30 p.m., DPS #1 placed the hand clapper back inside Client #3's left hand. At 12:35 p.m., DPS #1 was observed</p>	W 120	<p>Individual #3's QIDP reported to the day program, and inserviced the staff on the infection control on</p> <p>Refer to attachment # 2</p> <p>In the future, the facility's QIDP will ensure that the day program staff implement the infection control protocol at all times.</p> <p>In addition, the QIDP will make the unannounced visits at the day program on a regular basis.</p>	3-21-14	

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W 120	Continued From page 3 to rub hand sanitizer on both of Client #3's hands prior to lunch time. When DPS #1 loosened Client #3's left hand, the clapper was observed to fall into a portion of the client's meal, which was pureed. DPS #1 immediately removed the clapper from the plate, placed the clapper on the table, grabbed Client #3's spoon, scooped a portion of the pureed food out where he thought the clapper landed and began to feed the client her lunch. Interview with DPS #1 on the same day at 12:50 p.m., revealed that he thought he had scooped up the portion of Client #3's food where the hand clapper landed. Further interview revealed that he probably should have requested another plate of food for Client #3. When asked, DPS #1 stated that he had received training on the prevention of infection control measures, however, could not recall the date. Interview with the DPCM and review of DPS #1 personnel training files on March 19, 2014, at 12:55 p.m. confirmed that DPS #1 had received training on infection control procedures on November 27, 2013. At the time of the survey, the day program staff failed to ensure proper infection control procedures were used during lunch time for Client #3.	W 120	Individual #3's QIDP reported to the day program, and inserviced the staff on the infection control on Refer to attachment # 2 In the future, the facility's QIDP will ensure that the day program staff implement proper infection control procedures at all times. In addition, the QIDP will make the unannounced visits at the day program on a regular basis. Individual #3's QIDP reported to the day program, and inserviced the staff on the infection control on Refer to attachment # 2 In the future, the facility's QIDP will ensure that the day program staff implement proper infection control procedures at all times. In addition, the QIDP will make the unannounced visits at the day program on a regular basis.	3-21-14	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client,	W 124			

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W 124	<p>Continued From page 4</p> <p>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 their legal guardian to be informed of the sedation medication administered prior to dental appointments, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>During the entrance conference on March 19, 2014, beginning at 9:00 a.m., interview with the PC revealed that Client #2 had a court appointed guardian. According to the PC, the guardian operated as the client's designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of his medications.</p> <p>On March 21, 2014, at 9:58 p.m., review of the HRC minutes dated October 2013, revealed Client #3 was approved for Xanax 1 mg one hour prior to her dental on October 15, 2013. At approximately 11:10 a.m., review of the corresponding MAR dated October 2013 confirmed that the aforementioned Xanax was administered one hour prior to the dental appointment on October 15, 2013.</p> <p>Interview with the QIDP on March 21, 2014, at approximately 11:45 a.m., revealed that after</p>	W 124	<p>It is stipulated in RCM's policy that consents used for sedation are obtained from the surrogate decision makers/guardians, and are also approved by the the Human Rights Committee prior to each medical appointment. Individual #2 's consent for the use of sedation was signed by her guardian prior to the dental appointment on October 15, 2013; however, the facility's nurse could not locate the approved consent. Another consent was resubmitted to individual 2's medical guardian for approval on 3-21-14</p> <p>The sedation was presented to the Human Rights committee on 3-24-14</p> <p>Refer to attachments # 3.1 & 3.2</p> <p>In the future, the facility nurse and QIDP will ensure that all consents for sedation are approved by the surrogate decision makers/guardian prior to the medical appointments.</p> <p>Additionally, all record must be filed, and available upon request.</p>		

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W 124	Continued From page 5 looking through Client #2's medical records, there was no evidence that informed consent had been obtained from the client's healthcare decision-maker prior to the administration of the sedation. On March 20, at 12:48 p.m., review of Client #2's psychological assessment dated September 18, 2014, revealed that the "client's functioning and lack of structured academic training precluded independent advocacy with particular reference to her health, finances and placement." The client cannot execute a durable power of attorney. At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to the client and/or the client's legal guardian for the use of the aforementioned sedation.	W 124	Refer to W 124 P. 5 Attachment # 3.1 and 3.2	3-22-14	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, facility staff failed to ensure client choice during snack and dinner time, for six of six clients in the sample. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. On March 19, 2014, at 4:01 p.m., the six clients were observed eating snacks at the dining table.	W 247	Refer to W 124 P. 5 Attachment # 3.1 and 3.2 All staff were inserviced by the facility's QIDP on the individuals' opportunity for choice and decision making on Refer to attachment #4 In the future, the facility management will ensure that the individuals are provided the opportunity to exercise their independence by permitting the the opportunity for choice in selecting food items.	3-22-14 3-21-14	

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W 247	<p>Continued From page 6</p> <p>DPS #1 that were assisting at the table stated that the snack consisted of strawberry yogurt. DSP #1, who prepared the snack, confirmed that all six clients received the same snack (strawberry yogurt). At no time did the staff offer clients the option of having a different snack item.</p> <p>2. On March 19, 2014, beginning at 6:06 p.m., dinner observations revealed DSP #1 placed ranch dressing on the salads of five of the five clients that received salad with their dinner meal. At no time did the staff offer clients the option of having a different flavored salad dressing.</p> <p>3. On March 20, 2014, at 4:54 p.m., observations during snack time revealed all six clients received goldfish crackers for their snack. At no time did the staff offer clients the option of having a different snack item.</p> <p>Interview with the PC on March 21, 2014, at approximately 11:00 a.m., revealed there were several other snacks and salad dressings available during snack/dinner time on March 19, 2014 and March 20, 2014. When asked, the PC stated that Client #2 was more than capable of expressing her wants and needs. The PC further stated that it was convenient for the staff to serve the clients the same snacks and salad dressing on the aforementioned dates.</p> <p>During the environmental inspection on March 21, 2014, at 11:05 a.m., observations revealed there were various snack items including mixed fruit, chip ahoy chewy cookies, Jell-O pudding, Cheetos puffs, fruit cups and low-fat honey maid graham crackers observed in the kitchen cabinets. Further observations revealed there were also various flavored salad dressings (blue</p>	W 247	<p>Refer to W 247 P. 6 (1) Attachment #4</p> <p>Refer to W 247 P. 6 (1) Attachment #4</p> <p>Refer to W 247 P. 6 (1) Attachment #4</p> <p>Refer to W 247 P. 6 (1) Attachment #4</p>	<p>3-21-14</p> <p>3-21-14</p> <p>3-21-14</p> <p>3-21-14</p>	

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W 247	Continued From page 7 cheese, thousand island and ranch dressing) inside the refrigerator. At the time of the survey, the facility's staff failed to ensure client's exercised their independence by permitting opportunity for choice in selecting different food items.	W 247	Refer to W 247 P. 6 (1) Attachment #4	3-21-14	

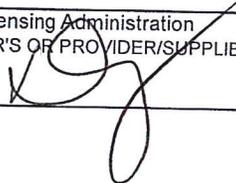
Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD-03-028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from March 19, 2014 through March 21, 2014. A sample of three residents was selected from a population of three females with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <ul style="list-style-type: none"> - Human Rights Committee - HRC - Milligrams - mg -Cubic centimeter - cc - Program Coordinator - PC - Individual Support Plan - ISP - Direct Support Professional - DSP - Day Program Staff - DPS - Group Home for Individuals with Intellectual Disabilities - GHIID - Registered Nurse - RN - Qualified Intellectual Disabilities Professional - QIDP - Licensed Practical Nurse - LPN - Milliliters - ml - Day Program Case Manager - DPCM 	1 000		
1 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p>	1 500		

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



TITLE

CSO

(X6) DATE

4/10/14

Health Regulation & Licensing Administration

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I 500	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure the rights of each resident and their legal guardian to be informed of the sedation medication administered prior to dental appointments, for one of three residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>During the entrance conference on March 19, 2014, beginning at 9:00 a.m., interview with the PC revealed that Resident #2 had a court appointed guardian. According to the PC, the guardian operated as the resident's designated surrogate healthcare decision-maker due to the resident's inability to give informed consent for the use of his medications.</p> <p>On March 21, 2014, at 9:58 p.m., review of the HRC minutes dated October 2013, revealed Resident #3 was approved for Xanax 1 mg one hour prior to her dental on October 15, 2013. At approximately 11:10 a.m., review of the corresponding MAR dated October 2013 confirmed that the aforementioned Xanax was administered one hour prior to the dental appointment on October 15, 2013.</p> <p>Interview with the QIDP on March 21, 2014, at approximately 11:45 a.m., revealed that after looking through Resident #2's medical records, there was no evidence that informed consent had been obtained from the resident's healthcare decision-maker prior to the administration of the sedation.</p> <p>On March 20, at 12:48 p.m., review of Resident #2's psychological assessment dated September</p>	I 500	<p>It is stipulated in RCM's policy that consents used for sedation are obtained from the surrogate decision makers/guardians, and are also approved by the the Human Rights Committee prior to each medical appointment. Individual #2 's consent for the use of sedation was signed by her guardian prior to the dental appointment on October 15, 2013; however, the facility's nurse could not locate the approved consent. Another consent was resubmitted to individual #2's medical guardian for approval on 3-22-14</p> <p>The sedation were presented to the Human Rights committee on 3-24-14</p> <p>Refer to attachments # 3.1 & 3.2</p> <p>In the future, the facility nurse and QIDP will ensure that all consents for sedation are approved by the surrogate decision makers/guardian prior to the medical appointments.</p> <p>Additionally, all record must be filed, and available upon request.</p>	

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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) COMPLETE DATE
I 500	<p>Continued From page 2</p> <p>18, 2014, revealed that the "resident's functioning and lack of structured academic training precluded independent advocacy with particular reference to her health, finances and placement." The resident cannot execute a durable power of attorney.</p> <p>At the time of the survey, the GHIID failed to provide evidence that Resident #2's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to the resident and/or the resident's legal guardian for the use of the aforementioned sedation.</p>	I 500	<p>It is stipulated in RCM's policy that consents used for sedation are obtained from the surrogate decision makers/guardians, and are also approved by the the Human Rights Committee prior to each medical appointment. Individual #2 's consent for the use of sedation was signed by her guardian prior to the dental appointment on October 15, 2013; however, the facility's nurse could not locate the approved consent. Another consent was resubmitted to individual #2's medical guardian for approval on 3-22-14</p> <p>The sedation were presented to the Human Rights committee on 3-24-14</p> <p>Refer to attachments # 3.1 & 3.2</p> <p>In the future, the facility nurse and QIDP will ensure that all consents for sedation are approved by the surrogate decision makers/guardian prior to the medical appointments.</p> <p>Additionally, all record must be filed, and available upon request.</p>	



Attachment # 1

Administrative Office
900 Second Street, NE - Suite 8
Washington, DC 20002
(202) 789-1930 Phone
(202) 789-1483 Fax

IN-SERVICE / TRAINING REPORT

Title: what is confidential? HIPPA Date: 3/24/14
Location: 2420 T street S.E WDC 20020

No. of Sessions: 1 Length of Session: 30mins

Outline: what is confidential documentation

*Attach Agenda

Resource Used: HIPPA See attached

*Attach Documentation/Resource Materials

Instructor: Aiona Beaty

Signature: Aiona Beaty

PRINT NAME	POSITION/SHIFT	SIGNATURE
Blaise, Pekam Alana	DSP/TME 3-11	
Hattie Menon	DSP 7-3	
Nanpark Eveline	DSP/TME 3-11	
Nheha Eyiba	DSP/TME	
name, Chamber	DSP 11-7	
Nathalie, Saintvil	DSP/TME	
Nauda, Kamara	DSP TME	
DISAUNDRA MUMFORD	DSP/TME 3-11PM	
Veronica Wall	DSP 1-9 ^{PM}	
ARIHUR BAKER	DSP	
Timke Sbadamosi	DSP 11p-2am	

Privacy Protocol

- ✦ Each individual should own a winter and summer bath robe.
- ✦ When individuals are in their bedrooms, dressing, grooming, the door should be closed or slightly ajar allowing for privacy.
- ✦ When individuals are in the bathroom, the door should be closed unless otherwise specified due to safety concerns.
- ✦ Individuals should wear bath robes when coming out of their bedrooms/ bathroom in night wear.
- ✦ Individuals should be encouraged to fasten clothing appropriately, if observed otherwise, they should be directed to bedroom or bathroom to make corrections.
- ✦ When individuals are observed masturbating (or engaged in other forms of sexual expressions) in areas other than bedrooms or bathroom, they should be directed to those areas.
- ✦ Individuals / staff should always knock or be assisted to knock on closed doors.
- ✦ Individuals should not be allowed in other's bedroom without permission.
- ✦ Only one individual should use or occupy the bathroom at a time.

What is Confidential?

Keeping information you have about an individual private.

Ways to keep information confidential:

- 1) Not talking about individual we support to our family members
- 2) Not leaving papers around for others to see
- 3) Locking up records when finished with them
- 4) Closing doors when having private conversations
- 5) Logging out of computers when you need to walk away