

Health Regulation & Licensing 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 08/28/2013
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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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1 000 INITIAL COMMENTS

A licensure survey was conducted from August 26, 2013 through through August 28, 2013. A sample of two residents was selected from a population of four males, with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and two day programs, interviews with two residents' guardians, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

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Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

1 090 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the group home for individuals with intellectual disabilities (GHIID) failed to maintain the environment in accordance with the needs of four of four residents of the facility. (Residents #1, #2, #3, and #4)

The findings include:

On August 28, 2013, beginning at 11:30 a.m., the surveyor was accompanied by lead direct support

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

Angela E. Jambo

TITLE
Program Director

(X6) DATE
9-16-13

Health Regulation & Licensing Administration

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1090 Continued From page 1

staff (Staff) #4 to conduct an inspection of the environment. The findings identified in this report were confirmed during the observations, and the subsequent discussion with Staff #4 and qualified intellectual disabilities professional (QIDP) #1 on August 28, 2013, at 4:45 p.m.

1. Wrinkles were observed in the carpet installed on the floor of the bedroom of Residents #2 and #4. The wrinkles were located at the entrance door from the hallway, and between the residents' beds, near the head of the beds, and created potential trip hazards. Interview with Staff #4 during the environmental observation revealed that Resident #4's vision was severely impaired and that Resident #2 had a significant gait deficit, which impaired his ambulation. The aforementioned health concerns of Residents #4 and #2 were confirmed through the record review on August 28, 2013, at 2:39 p.m., and on August 28, 2013, at 3:13 p.m. respectively.

2. Resident #1's recliner, which was located in the living room, had the vinyl covering worn off, exposing the fabric underneath on the seat, arm and back. The vinyl covering was worn off on the back of Resident #3's recliner, which was also located in the living room. The seat of the couch in the living room was sagging, which caused the seat to be too low for comfortable sitting.

3. The right side of the drawer of Resident #3's nightstand was missing. The knob necessary to open the door of the same nightstand was also missing.

4. Rust was observed on the bathtub located in the basement bathroom.

5. Several splintered areas were observed on the

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The wrinkles on the carpet on the floor of the bedroom of residents #2 and #4 creating a potential trip hazards have been removed on 9-9-13

In the future, the house management will ensure that the facility environment is free from objects that can create potential hazards.

Resident #1's and #3's recliners as well as the couch located in the living room were replaced on 9-8-13

Refer to attachment #1
In the future, the facility management will ensure that the furniture in the home are in good condition.

The right side of the drawer of resident #3's nightstand as well as the knob were replaced on 9-9-13

The rust observed on the bathtub located in the basement was removed on 9-9-13

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1090	Continued From page 2 hand railing of the ramp. Additionally, several corners of the hand railing on the ramp were misaligned, which created a potential for injury. 6. The paved cement blocks located directly behind the van were misaligned, due to wide spaces in between them and not being level with each other. These concerns created a potential trip hazard. 7. The top step was detached from the steps leading from the back yard to the side of the house, creating a potential trip hazard. 8. Debris and small broken limbs were observed in the overgrowth of green plants beside the steps leading from the back yard to the side of the house, where the basement entrance was located. These were unsightly and created a potential hiding area for insects and other pests. 9. The downspout installed on the right (front) corner of the house ended approximately four inches above the ground, This allowed water from the roof to run directly toward the foundation of the building. 10. Trash was observed in the window wells on the exterior of the facility.	1090	The splintered areas observed on the hand railing of the ramp, and the misaligned corners on the on the hand railing were repaired on 9-9-13 6. The paved cement blocks located behind the van were aligned on 9-16-13 7. The detached top steps leading to back yard were repaired on 9-16-13 8. The debris and small broken limbs besides the steps leading from the back yard to the side of the house were removed on 9-16-13 9. The downspout installed on the right from corner of the house that ended approximately five inches from the ground was repaired on 9-16-13. 10. The trash observed in the window wells on the exterior of the facility was removed on 9-9-13	
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1379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall	1379		
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I 379	Continued From page 3 be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HLRA), for one of the two residents in the sample. (Resident #2) The finding includes: The review of unusual incidents on August 27, 2013, at 9:35 a.m., revealed that on September 19, 2012, at 8:00 a.m., "[Resident #2's] bed was found to have evidence of what may be bed bugs." According to the facility's investigation report, dated October 19, 2012, the existence of bed bugs was verified. Continued review of the investigation report on August 27, 2013, at 9:45 a.m., revealed immediate measures implemented included professional extermination, the purchase of a new bed and mattress for Resident #2, shampooing of rugs, and laundering of clothing, bed linens and blankets. Further record review revealed staff were retrained on residents' rights and sanitation on September 28, 2012. The review of the facility's internal incident report, however revealed that the incident was not reported to DOH until October 18, 2012.	I 379	It is RCM's policy that all of the incidents are reported timely to all of the entities. The QIDP did follow the protocol by sending the notifications to all the entities; however, he failed to fax the incident report to DOH incident manager on October 18, 2012. The QIDP was inserviced by the Program Director on the incident management on 8-28-13. Refer to attachment #2 In the future, the facility QIDP will ensure that all incidents are reported timely, and that the incidents are immediately reported to DOH incident manager by telephone, and that a follow-up written report is submitted to DOH with 24hrs of the next work day as required.	
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1379	<p>Continued From page 4</p> <p>Interview with the DOH incident manager on August 28, 2013, at 2:57 p.m., revealed that the facility reported the incident by telephone on October 18, 2012, however, DOH never received the written report of the incident. Interview with the facility's qualified intellectual disabilities professional (QIDP) #1 on August 28, 2013, at 4:40 p.m., confirmed that the incident was not reported to DOH until October 18, 2012.</p> <p>At the time of the survey, the facility failed to ensure that DOH was notified of the incident immediately by telephone, and that a follow-up written report was submitted to DOH within twenty-four (24) hours or the next work day, as required.</p>	1379	<p>It is RCM's policy that all of the incidents are reported timely to all of the entities. The QIDP did follow the protocol by sending the notifications to all the entities; however, he failed to fax the incident report to DOH incident manager on October 18, 2012.</p> <p>The QIDP was inserviced by the Program Director on the incident management on 8-28-13. Refer to attachment #2</p> <p>In the future, the facility QIDP will ensure that all incidents are reported timely, and that the incidents are immediately reported to DOH incident manager by telephone, and that a follow-up written report is submitted to DOH with 24hrs of the next work day as required.</p>	