

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

PRINTED: 04/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

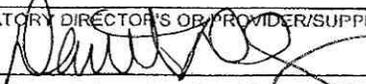
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/12/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>R C M OF WASHINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1318 45TH PLACE, NE WASHINGTON, DC 20019</b>
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W 000	INITIAL COMMENTS  A recertification survey was conducted from April 10, 2013 through April 12, 2013. A sample of three clients was selected from a population of two males and three females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.  The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
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, interview and record review, the facility failed to ensure privacy while client's used the bathroom, for one of three clients in the sample. (Client #2)  The finding includes:  On April 10, 2013, at 8:30 a.m., Client #2 was observed sitting on the toilet with the door wide opened. His pants were observed down,	W 130		

*Recewed 5/2/13*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>CSD</i>	(X6) DATE <i>5/1/13</i>
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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 130	Continued From page 1  exposing his legs and buttocks. At 8:31 a.m., the direct support staff (Staff #5) pulled his pants up then sat him back on the toilet. At 8:33 a.m., Staff #5 assisted the client from the bathroom to the van.  Review of the privacy protocol on April 10, 2013, at 4:35 p.m., revealed that "when individuals are in the bathroom, the door should be closed unless otherwise specified due to safety concerns."  Interview with Staff #5 on April 10, 2013, at approximately 8:00 p.m., revealed that Client #2 does not like to close the bathroom door. Further interview revealed she is required to stand by the door and encourage the client to keep the door close.	W 130	All staff were inserviced on Privacy by the QIDP on 4-15-13 Refer to attachment #4  In the future, the facility staff and management will ensure that individual #2's as well as other individuals' privacy is respected while using the bathroom.	
W 140	483.420(b)(1)(i) CLIENT FINANCES  The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that justified the withdrawals/expenditures from client's personal accounts, for one of three clients in the sample. (Client #3)  The finding includes:  On April 12, 2013, beginning at 3:20 p.m., review of Client #3's financial records, revealed \$82.95 was withdrawn from the client's account on	W 140	The amount for the missing receipt was redeposited in individual's #'s account on 5-1-13 Refer to attachment #2  In the future, the facility management will ensure that all of the individuals' accounts are up to date, and reflect all the completed transactions.	

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W 140	Continued From page 2 October 29, 2012. Further review revealed there were no receipts available to justify the withdrawal.  Interview with the house manager (Staff #2) on April 12, 2013, at approximately 4:00 p.m., revealed he was not able to find the receipt to justify the withdrawals.  At the time of the survey, the facility failed to provide a complete account of clients personal funds.	W 140	The amount for the missing receipt was redeposited in individual's #'s account on 5-1-13 Refer to attachment #2 In the future, the facility management will ensure that all of the individuals' accounts are up to date, and reflect all the completed transactions.
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure each client's privacy program was implemented consistently, for one of three clients in the sample. (Client #2)  The finding includes:  On April 10, 2013, at 8:30 a.m., Client #2 was observed sitting on the toilet with the door wide opened. His pants were observed down, exposing his legs and buttocks. At 8:31 a.m., the	W 249	All staff were inserviced on Privacy by the QIDP on 4-15-13 Refer to attachment #4 In the future, the facility staff and management will ensure that individual's 2 as well as other individuals' privacy is respected while in the bathroom.

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W 249	Continued From page 3 direct support staff (Staff #5) pulled his pants up then sat him back on the toilet. At 8:33 a.m., Staff #5 assisted the client from the bathroom to the van. At no time was the client encouraged to or did staff #5 close the door.  Review of Client #2's individual program plan (IPP) dated January 11, 2013 on April 11, 2013, at 4:16 p.m., revealed the following objective:  The client "will close the bathroom door with verbal prompts from the staff 75% of trials for three consecutive months by December 2013."  Interview with Staff #5 on April 10, 2013, at approximately 8:00 p.m., revealed that Client #2 does not like to close the bathroom door. Further interview revealed she is required to stand by the door and encourage the client to keep the door close, but she failed to do so.  The facility failed to encourage the client to close the bathroom door while he used the bathroom on April 10, 2013, as recommended in the IPP.	W 249	All staff were retrained by the QIDP on individual #2' IPP on 4-15-13 Refer to attachment #5 In the future, the facility QIDP will ensure that the staff implement the individuals' IPPs as written.		
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 observation, interview and record review, the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly, for three of three clients included in the sample. (Client #1, #2 and #3)	W 362			

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W 362	Continued From page 4 The findings include:  1. Observations of the medication administration on April 10, 2013, at 7:25 p.m., revealed Client #1 received phenobarbital, Baclofen, Calcium, Keppra and Naproxen. Review of Client #1's medical record on April 11, 2013, at 9:54 a.m., revealed there was no pharmacy review between March 27, 2012 through February 8, 2013 (11 months).  2. Medication administration observation on April 11, 2013, at 7:42 p.m., revealed Client #3 received Constulose, Calcium, Tegretol, Lovastatin and Topiramate. Review of Client #3's medical record on April 12, 2013, at 9:46 a.m., revealed there was no pharmacy review between March 15, 2012 through February 8, 2013 (11 months).  3. Similarly, medication administration observation on April 10, 2013, at 7:56 p.m., revealed Client #2 received Calcium, Carbamazepine, Clomipramine, Geodon, Lactulose, Atorvastatin, Paroxetine, Ranitidine, Senna and Vitamin D. Review of Client #2's medical record on April 11, 2013, at 3:04 p.m., revealed there was no pharmacy review between March 13, 2012 through February 8, 2013 (11 months).  Interview with the registered nurse (RN, Staff #4) on April 12, 2013, at approximately 3:00 p.m., revealed the pharmacist is required to review the clients drug regimen every quarter.  At the time of the survey, the facility failed to provide evidence that a pharmacist conducted a	W 362	1.& 2. The facility RN was inserviced by the DON on the Pharmacy review schedule on 4-30-13 Refer to attachment #7 Additionally, the Pharmacist has reviewed all of the individuals's medications on 5-1-13 In the future, the nursing team will ensure that the individuals' medications are reviewed by the pharmacist on a quarterly basis.  The facility RN was inserviced by the DON on the Pharmacy review schedule on 4-30-13 Refer to attachment #7 Additionally, the Pharmacist has reviewed all of the individuals's medications on 5-1-13 In the future, the nursing team will ensure that the individuals' medications are reviewed by the pharmacist on a quarterly basis.		

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W 362	Continued From page 5 quarterly reviews as required.	W 362			
W 369	483.460(k)(2) DRUG ADMINISTRATION  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 all eye drops were administered without error, for one of five clients residing in the facility. (Client #3)  The finding includes:  On April 10, 2013, beginning at 7:36 p.m., the trained medication employee ( TME, Staff #5) began to prepare Client #3's medication. At 7:38 p.m., Staff #6 wheeled the client to the Staff #5. Staff #5 then told Staff #6 " I'm going to need you to help me to administer her eye drops." Staff #6 said "ok" and walked away. At 7:42 a.m., Staff #5 administered Constulose, Calcium, Tegretol, Lovastatin and Topiramate to Client #3. Staff #5 then locked the aforementioned medications and the eye drops in the closet. Staff #5 indicated that the medication administration was completed for Client #3.  On April 10, 2013, at approximately 8:00 p.m., review of the client's medication administration review (MAR) and physician 's order sheets (POS) dated April 1, 2013, revealed an order to instill one drop of Systane eye drops at 7:00 p.m.  Interview with Staff #5 on April 10, 2013, at	W 369	All of the facility's TMEs were inserviced by the facility's RN on the drug administration with emphasis on the eye drops on 4-29-13 Refer to attachment #6 In the future, the facility nursing team will ensure that the TMEs administer the medications as prescribed.		

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W 369	Continued From page 6 approximately 8:15 p.m., revealed she was going to administer the eye drops "later on after she took her shower."  At the time of the survey, the facility failed to ensure that all drugs were administered without error.	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the use of a recommended elbow brace, for two of three clients in the sample. (Client #1)  The finding includes:  1. On April 10, 2013, at 8:37 a.m., Client #1 was observed in her wheelchair as she waited for staff to transport her on the van. Observations revealed, her hands were contracted and her elbows appeared to be contracted.  On April 11, 2013, at 11:37 a.m., review of the "Physical Therapy Notes" dated September 12, 2012, revealed Client #1 is required to wear an elbow brace. The note also stated that the use of the brace is "to decrease the tone of both upper extremities."	W 436	All staff were inserviced on individual #1's PT recommendations on 4-15-13 Refer to attachment #8 In the future, the facility's QIDP will ensure that the staff implement individual #1 recommendations as prescribed by the PT.	

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W 436	Continued From page 7  Observation on April 12, 2013, at approximately 2:00 p.m., revealed Staff #6 placed Client #1's elbow brace on her arm. When asked, Staff #6 confirmed that Client #1 did not wear her elbow brace on April 10, 2013, as required.  At the time of survey, the facility failed to ensure Client #6 wore her elbow brace as recommended by the physical therapist.	W 436	All staff were inserviced on individual #1's PT recommendations on 4-15-13 Refer to attachment #8 In the future, the facility's QIDP will ensure that the staff implement individual #1 recommendations as prescribed		
W 455	483.470(l)(1) INFECTION CONTROL  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure effective infection control procedures (hand washing) was implemented, for one of the three clients included in the sample. (Client #2)  The finding includes:  On April 10, 2013, at 8:30 a.m., Client #2 was observed sitting on the toilet with the door wide opened. His pants were observed down, exposing his legs and buttocks. At 8:31 a.m., the direct support staff (Staff #5) pulled his pants up then sat him back on the toilet. At 8:33 a.m., Staff #5 assisted the client from the bathroom to the van without washing or prompting him to wash his hands.  Review of the in-service training records on April 10, 2013, beginning at approximately 3:00 p.m.,	W 455	All staff were inserviced on infection control by the QIDP on 4-15-13 Refer to attachment #9 In the future, the facility management will ensure that the staff encourage the individuals to wash their hands in order to prevent the spread of germs, and to promote good hand washing habits.		

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W 455	Continued From page 8 revealed that all staff including Staff #5 received training on infection on March 4, 2013. Observations on April 10, 2013, however, revealed the training had not been effective.	W 455		
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1 000	INITIAL COMMENTS  A licensure survey was conducted from April 10, 2013 through April 12, 2013. A sample of three residents was selected from a population of two males and three females with varying degrees of intellectual disabilities.  The findings of the survey were based on observations in the home and two day program, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000		
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 and interview, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all dresser drawers were aligned, for one of five residents in the facility. (Residents #5)  The finding includes:  Observation during the inspection of the environment on April 12, 2013, beginning at 10:25 a.m., revealed Resident #2's lower night stand drawers was off the hinges and was not able to	1 090	Individual #2's night stand was replaced by a new one on Refer to attachment #1 5-1-13 In the future, the facility management will ensure that all the individuals' equipment are in a good working and repaired condition.	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

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(X6) DATE

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If continuation sheet 1 of 7

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I 090	Continued From page 1  be close.  The house manager (Staff #2), who was present during the environmental inspection, acknowledged the aforementioned finding and revealed that he would address the finding.	I 090			
I 189	3508.7 ADMINISTRATIVE SUPPORT  Each GHMRP shall maintain records of residents ' funds received and disbursed.  This Statute is not met as evidenced by: Based on staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to provide evidence that justified the withdrawals/expenditures from resident's personal accounts, for one of three residents included in the sample. (Resident #3)  The finding includes:  On April 12, 2013, beginning at 3:20 p.m., review of Resident #3's financial records, revealed \$82.95 was withdrawn from the resident's account on October 29, 2012. Further review revealed there were no receipts available to justify the withdrawal.  Interview with the house manager (Staff #2) on April 12, 2013, at approximately 4:00 p.m., revealed he was not able to find the receipt to justify the withdrawals.  At the time of the survey, the facility failed to provide a complete account of clients personal funds.	I 189	The amount for the missing receipt was redeposited in individual's #'s account on 5-1-13 Refer to attachment #2 In the future, the facility management will ensure that all of the individuals' accounts are up to date, and reflect all the completed transactions.		



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I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR) for one of one licensed practical nurse. (Staff #10)  The finding includes:  Review of the personnel records on April 12, 2013, beginning at 2:20 p.m., revealed the GHIID failed to have available for review a current CPR certification for the LPN (Staff #10). This was acknowledged by the house manager (Staff #2) on the same day at approximately 4:00 p.m. Further interview revealed he will retrieve it from human resource or the nurse.	I 227	Staff # 10's CPR is currently on file Refer to attachment #3c In the future, the provider will ensure that the employees' files are up to date, and available upon request.	4-30-13
I 422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.  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 ensure	I 422		

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I 422	Continued From page 4  each resident's privacy program was implemented consistently, for one of the three residents in the sample. (Resident #2)  The finding includes:  On April 10, 2013, at 8:30 a.m., Resident #2 was observed sitting on the toilet with the door wide opened. His pants were observed down, exposing his legs and buttocks. At 8:31 a.m., the direct support staff (Staff #5) pulled his pants up then sat him back on the toilet. At 8:33 a.m., Staff #5 assisted the resident from the bathroom to the van. At no time was the resident encouraged to or did staff #5 close the door.  Review of Resident #2's individual program plan (IPP) dated January 11, 2013 on April 11, 2013, at 4:16 p.m., revealed the following objective:  The resident "will close the bathroom door with verbal prompts from the staff 75% of trials for three consecutive months by December 2013."  Interview with Staff #5 on April 10, 2013, at approximately 8:00 p.m., revealed that Resident #2 does not like to close the bathroom door. Further interview revealed she is required to stand by the door and encourage the resident to keep the door close, but she failed to do so.  The facility failed to encourage the resident to close the bathroom door while he used the bathroom on April 10, 2013, as recommended in the IPP.	I 422	All staff were inserviced on Privacy by the QIDP on 4-15-13 Refer to attachment #4 In the future, the facility staff and management will ensure that individual's 2 privacy is respected while he is in the bathroom.  All staff were retrained on individual #2's IPP on 4-15-13 Refer to attachment #5 In the future, the facility QIDP will ensure that the staff implement the individuals' IPPs as written.	
I 473	3522.4 MEDICATIONS  The Residence Director shall report any irregularities in the resident ' s drug regimens to	I 473		

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I 473	<p>Continued From page 5</p> <p>the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all eye drops were administered without error, for one of five clients residing in the facility. (Resident #3)</p> <p>The finding includes:</p> <p>On April 10, 2013, beginning at 7:36 p.m., the trained medication employee ( TME, Staff #5) began to prepare Resident #3's medication. At 7:38 p.m., Staff #6 wheeled the resident to the Staff #5. Staff #5 then told Staff #6 " I'm going to need you to help me to administer her eye drops." Staff #6 said "ok" and walked away. At 7:42 a.m., Staff #5 administered Constulose, Calcium, Tegretol, Lovastatin and Topiramate to Resident #3. Staff #5 then locked the aforementioned medications and the eye drops in the closet. Staff #5 indicated that the medication administration was completed for Resident #3.</p> <p>On April 10, 2013, at approximately 8:00 p.m., review of the resident's medication administration review (MAR) and physician ' s order sheets (POS) dated April 1, 2013, revealed an order to instill one drop of Systane eye drops at 7:00 p.m.</p> <p>Interview with Staff #5 on April 10, 2013, at approximately 8:15 p.m., revealed she was going to administer the eye drops "later on after she took her shower."</p> <p>At the time of the survey, the facility failed to</p>	I 473	<p>All of the facility's TMES were inserviced by the facility's RN on the drug administration with emphasis on the eye drops on 4-29-13</p> <p>Refer to attachment #6</p> <p>In the future, the facility nursing team will ensure that the TMES administer the medications as prescribed.</p>	
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I 473	Continued From page 6  ensure that all drugs were administered without error.	I 473		