

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

PRINTED: 02/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G231	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2012
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NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1778 VERBENA ST NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 26, 2012 through January 27, 2012. A sampling of three clients was selected from a population of six individuals with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations in the home and three day programs, interviews with direct support staff, day program 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	<p style="text-align: center;"><i>Received 3/1/12</i></p> <p style="text-align: center;">Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days, for one of the six clients residing in the facility. (Client #6) The finding includes: Review of the facility's incident management records on January 26, 2012, beginning at 3:00 p.m. revealed that on May 30, 2011, at 5:45 p.m.,	W 156		<p>It is RCM's policy that all results of the investigations are reported to the administrator or designated representative within five working days. The IMC was inserviced by the Program Director on the incident management protocol on 2-3-12 See attached #1.</p> <p>In the future, the facility management will ensure that the administrator is notified of the results of the investigations within five working days.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE COO	(X6) DATE 2/22/12
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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 156	Continued From page 1 the licensed practical nurse witnessed a direct support staff hit Client #6. Review of the corresponding investigative report revealed the investigation was initiated on May 30, 2011, and completed on June 8, 2011 (nine days after the incident occurred). The result of the investigation of the allegation of abuse was inconclusive. Interview with the facility's qualified intellectual disabilities professional (QIDP) on January 27, 2012, at approximately 11:00 a.m., confirmed the incident took place on May 30, 2011, and that the ensuing investigation was completed on June 8, 2011. Further discussion with the QIDP revealed that the results of the investigation were also reported to the administrator on June 8, 2011. At the time of the survey, the facility failed to ensure that the administrator was notified of the results of the investigation within five working days, as required by federal regulations.	W 156	It is RCM's policy that all results of the investigations are reported to the administrator or designated representative within five working days. The IMC was inserviced by the Program Director on the incident management protocol on See attached #1. In the future, the facility management will ensure that the administrator is notified of the results of the investigations within five working days.	2-3-12
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: Based on observation, interview and record review, the facility failed to ensure medication records were accurately maintained for one of three clients in the sample. (Client #2) The finding includes: On January 26, 2012, beginning at 5:45 p.m., the primary licensed practical nurse (PLPN) was observed to administer Lactulose 90 ml to Client	W 365		

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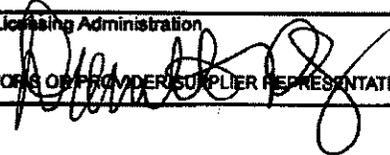
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W 365	<p>Continued From page 2 #2.</p> <p>On January 27, 2012, at approximately 11:30 a.m., review of the medication administration record (MAR) for January 2012, revealed documentation that Client #2 received Lactulose 60 ml on January 14, 2012 (7:00 a.m., 5:00 p.m., and 9:00 p.m.). Continued review of the MAR revealed documentation that Client #2 also received Lactulose 90 ml (7:00 a.m. and 5:00 p.m.), on January 14, 2012.</p> <p>Interview with the same PLPN on January 27, 2012, at 11:36 a.m., revealed that the order for Lactulose 60 ml TID was discontinued on January 14, 2012. Further discussion with the PLPN revealed that on January 14, 2012, the physician then prescribed Lactulose 90 ml BID (7:00 a.m. and 5:00 p.m.). According to the primary LPN, the new order for Lactulose 90 ml BID was implemented on the same day Lactulose 60 ml TID was discontinued. Consequently, as a result of the change, the the total amount of Lactulose administered to the client within the 24 hour period (January 14, 2012) was only 180 ml. The PLPN further stated, however, that the Lactulose 60 ml. TID had not been discontinued on the MAR on January 14, 2012, as required.</p>	W 365	<p>Individual's #2 Lactulose 60ml TID was discontinued on 1-14-12 as ordered; however, the electronic keeping system does not block multiple entries of discontinued medication, hence, the documentation error. The nurses have been trained by the DON on Best Practices in Nursing and on the proper documentation on the MAR.</p> <p>Refer to attachment #2</p> <p>In the future, the nursing management will ensure that all medications are administered as prescribed.</p>	

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 26, 2012 through January 27, 2012. A sampling of three residents was selected from a population of six individuals with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with direct support staff, day program and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior of the facility was maintained in a safe and orderly manner to meet the needs of six residents in the GHPID. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>1. On January 26, 2012, at 11:20 a.m., observation of a closet located in the living room revealed it contained an elevator that was not</p>	1 090	<p>It is the practice of RCM that all equipment be maintained in a good working condition. On January 1, 2012, the staff reported that the house elevator was not operating. Beacon Management, the company that maintains the elevator was contacted by the QIDP. The representative reported to the facility on 1-2-12 to assess the elevator He indicated that the door was broken from it tracks, and could not be repaired at that time. He indicated that he will order the part from the manufacturer, and the process will take about 2-3 weeks. Please refer to attachment #3</p>	

Health Regulation & Licensing Administration

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(X6) DATE

2/22/12

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If continuation sheet 1 of 3

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1 090	Continued From page 1 operable. Interview with the qualified intellectual disabilities professional (QIDP) indicated that the elevator was out of service until the new door, which was on order, was delivered and installed. 2. On January 27, 2012, at approximately 3:00 p.m., the QIDP accompanied the surveyor during observations of the environment. The following concerns were identified: a. The frame on the lent filter of the dryer was broken and disconnected from the mesh screen. b. Trash was observed on the floor beside and behind the hot water heater located in the utility room.	1 090	The elevator was repaired on The repair technician trained the QIDP on and all staff were trained on Refer to attachment # 4 In the future, the facility will ensure that the equipment is in good repair, and that all staff are trained in the use of the equipment. 2a The frame on the lent filter of the dryer was ordered on In the future, the facility management will ensure that all of the appliances are in a good working condition.	1-31-12 1-31-12 2-3-12 2-17-12
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and 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 group home for persons with intellectual disabilities (GHPID) failed to ensure that two of fifteen direct care professionals (Staff #2 and #6) and three of thirteen consultants (Consultant #3, #4 and #5) had a current health certificate available for review. The finding includes:	1 206	2.b The trash on the floor beside and behind the hot water heater in the utility room was discarded on	1-27-12

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I 206	Continued From page 2 On January 27, 2012, beginning at 11:30 a.m., review of the personnel records revealed the GHPID failed to have evidence of a current health inventory/certificate for Staff #2 and #6 and Consultants #3, #4, and #5. It should be noted that although Staff #2 had a health certificate on file, it was not signed by the physician that conducted the evaluation. Review of Staff #6's file provided evidence that a tuberculosis screen had been conducted, but there was no evidence that a health inventory/evaluation had been conducted. Furthermore, review of Consultant #3's file revealed a health evaluation was in the file, but there was no name on the actual health certificate/inventory.	I 206	Consultants # 3, 4, and 5 Health Certificates are currently on files. Refer to attachment #5 a, b, & c In the future, the provider will ensure that all of the personnel files are updated. Staff # 2, and 6 Health Certificates are currently on files. Refer to attachment #6 a & b In the future, the provider will ensure that all of the personnel files are updated.	