

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

PRINTED: 07/07/2010  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>09G065</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>06/24/2010</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>R C M OF WASHINGTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4316 ALABAMA AVE, SE<br/>WASHINGTON, DC 20019</b> |
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**W 000 INITIAL COMMENTS**

A recertification survey was conducted from 6/23/2010 through 6/24/2010. The survey was initiated using the fundamental survey process. A sample of two clients was selected from a resident population of three men with various degrees of intellectual and/or developmental disabilities.

The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.

**W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES**

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively monitor the day program to address a client's regression in learning a new skill, for one of two sampled clients. (Client #1)

The finding includes:

Record review at Client #1's day program on 6/23/2010, at 11:30 a.m., revealed he dropped from the independent level down to the verbal prompt level in learning money management skills. According to the data collection sheets, Client #1 functioned at the independent level for the month of 1/2010 on sixteen of sixteen trials. For the months of 2/2010 and 3/2010, Client #1 regressed to function at the "verbal prompt" level

**W 000**

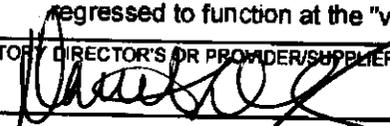
*Received 7/19/10*

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION ADMINISTRATION  
825 NORTH CAPITOL ST., N.E., 2ND FLOOR  
WASHINGTON, D.C. 20002

**W 120**

The QMRP reported to client #1's day program on 7-15-10, and met with the counselor to address client#1's lack of progress and regression; Client #1's goals were reviewed by both the IPP coordinator and QMRP Refer to attachment #1.

In the future, the facility Qmrp will monitor the clients' goals and data collection closely at the day program to ensure that progress or lack of progress is analyzed, and that criteria is revised accordingly.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br><b>CSO</b> | (X6) DATE<br><b>7/19/10</b> |
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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 120** Continued From page 1  
while achieving the same objectives. Despite his regression and lack of progress, Client #1's objective was increased to the next step and there was no evidence that either his lack of progress or regression had been assessed.

Interview with the Program Coordinator (PC) at the day program on the same day at approximately 11:55 a.m. confirmed Client #1's regression was not reviewed or assessed prior to moving up to the next level. In addition, the PC was not sure why Client #1 had regressed in his skill level between 1/2010 and 2/2010.

Interview with the Qualified Mental Retardation Professional (QMRP) on 6/24/2010, revealed he was not aware of the regression or the lack of progress in Client #1's money management program.

The facility failed to ensure an assessment of a client's regression and failure to progress to ensure consistent skill building.

**W 120**

The QMRP reported to client #1's day program on 7-15-10, and met with the counselor to address client#1's lack of progress and regression; Client #1's goals were reviewed by both the IPP coordinator and QMRP Refer to attachment #1.

In the future, the facility Qmnp will monitor the clients' goals and data collection closely at the day program to ensure that progress or lack of progress is analyzed , and that criteria is revised accordingly.

**W 148** 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &

The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

This STANDARD is not met as evidenced by:  
Based on interviews and record verification, the facility failed to consistently notify clients' family members or guardians of significant incidents, for three of the three clients residing in the facility. (Clients #1, #2 and #3)

**W 148**

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| W 148   | <p>Continued From page 2</p> <p>The finding includes:</p> <p>On the first day of survey, 6/23/2010, beginning at 12:40 p.m., review of incident reports and investigations in the facility revealed that an allegation of staff neglect was made on 5/12/2010. The incident report indicated that a direct support staff person left the three clients unattended in the facility for an unknown length of time. Further review of the incident report and related documents failed to show evidence that the clients' family members and guardians had been notified. Beginning at 2:00 p.m., interview with the facility's incident management coordinator (IMC) revealed that the qualified mental retardation professional (QMRP) was thought to have telephoned the guardians and families. After reviewing the incident report and corresponding investigation report (dated 5/17/2010), however, the IMC acknowledged that notification of family members and guardians had not been documented. When asked if anything had been sent to the families/guardians in writing, the IMC deferred to the QMRP.</p> <p>The QMRP was interviewed on 6/24/2010, at approximately 8:50 a.m. He stated that he had notified the family members by telephone. He stated that usually such notifications were documented on the initial incident report. However, after examining the 5/12/2010 incident report, he acknowledged that the telephone calls had not been documented, for reasons not known. When asked if anything had been sent to the families/guardians in writing, the QMRP indicated no, unless the IMC had sent written notifications.</p> | W 148   | <p>It is RCM policy to notify the clients' family members, and guardians each time an incident occurs. This notification is usually documented on the incident report. In this case, the QMRP, and IMC failed to document this information on the body of the incident report form prior to sending the report to different entities. The program Director did address this issue with the QMRP and IMC on 6-25-10. See attachment # 2</p> <p>In the future, the Qmrp will ensure that the families members and guardians are notified when an incident occurs; additionally, due to the time sensitivity of certain reports, a revised and complete copy of the incident report will be generated, and sent to different entities. Family members and guardians with email addresses will be notified electronically as well.</p> | 6-25-10.                                     |



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**W 247** Continued From page 4  
The individual program plan must include opportunities for client choice and self-management.

This STANDARD is not met as evidenced by:  
Based on observation, facility staff failed to ensure client choice during meals, for one of the two sampled clients. (Client #1)

The finding includes:

On 6/23/2010, dinner was served at 5:11 p.m. Client #1 and his two housemates were served the following food items family style: quiche, brussel sprouts, rice, apple juice and water. At 5:34 p.m., Client #1 stood up from the table and carried his plate to the kitchen. Although he had eaten most of his rice and quiche, he threw away all 8 of the brussel sprouts that he had been served. Two staff were present during the meal and did not ask about his vegetables. Staff also observed him discard the brussel sprouts and did not offer him an appropriate substitution to ensure proper nutrition. Moments later, Client #1 and his peers ate dessert (sugar-free vanilla pudding to all three men) and the meal ended. At no time were staff observed encouraging Client #1 to choose a vegetable that would suit his preferences.

**W 247**

All staff were trained by the nurse and QMRP on the appropriate substitution to ensure proper nutrition.

The emphasis was on the emphasis was on mealtime protocol, opportunity for choice and self management.

Refer to attachment #3

In the future the facility will ensure that the clients are given the opportunity to make choices during mealtime.

7-08-10

**W 252** 483.440(e)(1) PROGRAM DOCUMENTATION

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

**W 252**

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| W 252 | <p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by:<br/>Based on staff interview and record review, the facility failed to accurately and consistently document the client's progress in achieving a programmatic objective, for one of the two sampled clients. (Client #1)</p> <p>The finding includes:</p> <p>Record review on 6/23/2010, at 2:20 p.m., revealed Client #1's Physical Therapy assessment dated 1/2/2010, recommended that the facility initiate a formal strengthening program with the following goal and objective:</p> <p>Goal: [Client #1] will improve his strength.</p> <p>Objective: [Client #1] will perform exercises 3 times a week at 100% accuracy for 6 months.</p> <p>Additional record review on the same date and time revealed no data was collected for the months of 3/2010 and 4/2010. In addition, data collected for the months of 1/2010, 2/2010 and 5/2010 was inconsistent and was not being kept in the "3 times a week" frequency as outlined by the plan.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 6/24/2010, at 2:04 p.m., revealed there was no documented evidence to substantiate why the staff was not consistently implementing/documenting this client's progress. The QMRP further added that the staff stopped documenting on the "strengthening program" by order of the physical therapist (PT). Further record review on 6/24/2010, at approximately 2:15 p.m., revealed there was no documented evidence on file to</p> | W 252 | <p>All staff were inserviced on client #1's exercise program by the QMRP; the emphasis was on the importance of the data collection. Staff have resumed collecting data as requested by the PT.</p> <p>Refer to attachment # 4</p> <p>In the future, the Qmrp will ensure that client #1's data of the strengthening program is being collected as prescribed to ensure his health and safety.</p> | 7-8-10 |
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**W 252** Continued From page 6  
confirm that the PT made this request.

The facility failed to ensure accurate documentation of Client #1's strengthening program to ensure his health and safety as outlined in his individualized service plan.

**W 262** 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all behavior support plans were reviewed and approved by the Human Rights Committee (HRC) to ensure the health and safety of one of the two sampled clients. (Client #1)

The finding includes:

Client #1's behavior support plan (BSP) was revised on 12/31/2009, with the recommendation that the residential provider implement the updated BSP with the following goal and objectives:

Goal: [Client #1] will express his anger and frustration in socially appropriate behavior.

Objective #1: [Client #1] will decrease incidents of self-abuse (SIB - biting his arm/wrist, scratching his neck, slapping himself, picking at scabs) to 0 per month for 1 year.

**W 252**

**W 262**

It is the policy of this provider that all BSPs are presented to the BSPC, and HRC within 30 days after the final revision. Client #1's BSP was revised on April 16, 2010, presented to the Behavior Support Committee on May, 5, 2010, and to the HRC on May 17, 2010.  
Please refer to attached # 5 ( a, b, c.)

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| W 262 | <p>Continued From page 7</p> <p>Objective #2: Incidents of behavior associated with extreme agitation (i.e., screaming, pounding on table surfaces, running through the facility yelling to see his parents, attempts to exit his home when irritable w/o staff supervision) to 1 incident in 9 consecutive months.</p> <p>The updated plan further recommended that the facility "present a copy of this instrument to the Behavior Support Committee (BSC) and HRC for their review and approval." Interview with the facility's qualified mental retardation professional (QMRP) on 6/24/2010, revealed he could not find the HRC approval for this updated plan. The QMRP further explained he was the responsible person for ensuring the proper record keeping of the HRC minutes. The QMRP later stated the BSP had been reviewed around 6/2010, 6 months after the BSP had been changed; however, he was not able to provide the survey team with documentation of said review.</p> <p>The facility failed to ensure Client #1's BSP was being monitored, reviewed and/or approved for use timely by the Human Rights Committee to ensure Client #1's health and safety.</p> | W 262 | <p>It is the policy of this provider that all BSPs are presented to the BSPC, and HRC within 30 days after the final revision. Client #1's BSP was revised on April 16, 2010, presented to the Behavior Support Committee on May, 5, 2010, and to the HRC on May 17, 2010.</p> <p>Please refer to attached # 5 ( a, b, c.)</p> |  |
| W 426 | <p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure water</p>   | W 426 |  |  |

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| W 426  | <p>Continued From page 8</p> <p>temperatures did not to exceed 110 degrees Fahrenheit for three of three clients residing in the facility. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>1. On 6/24/2010, at approximately 2:30 p.m., the hot water temperature measured 118 degrees Fahrenheit in the kitchen sink.</p> <p>The house manager, who was present at the time, notified the facility's maintenance supervisor, who arrived at the facility at approximately 3:30 p.m. and turned down the setting on the hot water heater. At approximately 5:42 p.m., hot water temperature was retested at the kitchen sink and measured 112 degrees Fahrenheit. At 6:41 p.m., the water measured 106 degrees Fahrenheit. There was no evidence, however, that the facility had consistently ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit.</p> <p>2. On 6/24/2010, at approximately 5:50 p.m., review of the Shift Responsibility Report forms that were kept in the Daily Assignments Log book, revealed that staff had not documented hot water readings since the clients returned from vacation a week earlier, on 6/17/2010.</p> | W 426   | <p>All staff were trained on water temperature by the house manager on 7-08-10 with the importance of the consistent monitoring, and documentation.</p> <p>Refer to attachment # 6</p> <p>In the future the facility will ensure that the hot temperature is monitored, and documented on a regular basis. Additionally, any temperature exceeding 110 degrees Fahrenheit must be reported immediately to the house management, and maintenance supervisor.</p> | 7-08-10   |
| W 429  | <p>483.470(e)(2)(i) HEATING AND VENTILATION</p> <p>The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation, interview and measurement of room temperatures, the facility</p>   | W 429   |   |   |

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**W 429** Continued From page 9

failed to ensure that clients were not subjected to room temperatures exceeding the federal regulation of 68 - 81 degrees Fahrenheit (F), for one of the three clients residing in the facility. (Client #2)

The finding includes:

On 6/24/2010, at 8:40 a.m., the air temperature in the facility felt warm upon entry. The three clients were in the living room with staff and a ceiling fan was operating. The qualified mental retardation professional (QMRP), who was also present at the time, was asked whether the facility's central air conditioning (a/c) was operational. He looked at the thermostat, made an adjustment and said it was set for 75 degrees F. Clients #1 and #3 left for day program shortly thereafter. Client #2, however, remained home due to ill health. [Note: The central a/c had been functioning properly on the first day of survey, 6/23/2010.]

At 9:05 a.m., the air temperature was measured at 83 degrees F in the dining room/living room area. Client #2 stayed with staff in the living room while the survey team worked in the dining room. The room temperature continued to rise throughout the morning. [Note: Weather forecasters were predicting a high temperature of 98-100 degrees F that day.]

At 11:19 a.m., the temperature measured 86 degrees F in the dining room/living room area, at which time the QMRP and a surveyor determined that 2 air vents in the living room were closed shut, as was another vent in the dining room. Upon opening those vents, however, there was only marginally-cooler air blowing out. The QMRP subsequently reported the problem to the

**W 429**

The air conditioning was functioning properly on 6-23-10; however, on 6-24-10 the temperature became warm inside the home. All necessary measures were taken in order to cool the house, and to bring the temperature to normal. All the attempts were unsuccessful. In order to ensure the safety and well being of the clients, a plan was put in place which included to place the clients in another nearby ICF/MR home, to contact the A/C repairman, and to relocate the clients in the hotel until the air condition starts to operate properly.

Refer to attachment #7

In the future, the facility management will ensure that the preventive maintenance is implemented as indicated on "the preventive maintenance schedule".

Refer to attachment #8

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

PRINTED: 07/07/2010  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>09G065</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>06/24/2010</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>R C M OF WASHINGTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4316 ALABAMA AVE, SE<br/>WASHINGTON, DC 20019</b> |
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| (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 |
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**W 429** Continued From page 10  
main office. Meanwhile, Client #2 remained in the facility and was observed eating lunch at approximately 12:55 p.m.

Clients #1 and #3 were transported from their day program to another ICF/MR located nearby (operated by the same governing body), and Client #2 was taken there as well. The maintenance supervisor and an a/c repairman arrived at the facility at approximately 3:30 p.m. At 6:17 p.m., the QMRP reported that the a/c repairman had left the facility to obtain a replacement part.

At 6:45 p.m., the air temperature in the dining room/living room area measured 90 degrees F. The facility's program director presented a written plan to address the ongoing a/c outage. The plan included the following: two hotel rooms had been booked for the clients that night. The clients' medications would be taken to the hotel as well. The hotel stay would be extended another night if the a/c was not operational by 5:00 p.m. the following day. No client would return to the facility if the interior temperature went above 75 degrees.

On 6/25/2010, at approximately 11:30 a.m., a follow-up inspection of the facility revealed that the a/c was operating normally.

**W 429**

The air conditioning was functioning properly on 6-23-10; however, on 6-24-10 the temperature became warm inside the home. All necessary measures were taken in order to cool the house, and to bring the temperature to normal. All the attempts were unsuccessful. In order to ensure the safety and well being of the clients, a plan was put in place which included to place the clients in another nearby ICF/MR home, to contact the A/C repairman, and to relocate the clients in the hotel until the air conditioning starts to operate properly.

Refer to attachment #7

In the future, the facility management will ensure that the preventive maintenance is implemented as indicated on "the preventive maintenance schedule".

Refer to attachment #8

Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0178</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                              | (X3) DATE SURVEY COMPLETED<br><br><b>06/24/2010</b>  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>R C M OF WASHINGTON</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4316 ALABAMA AVE, SE<br/>WASHINGTON, DC 20019</b> |  |
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| R 000  | INITIAL COMMENTS<br><br>A licensure survey was conducted from 6/23/2010 through 6/24/2010. A sample of two residents was selected from a population of three men with various degrees of cognitive and intellectual disabilities.<br><br>The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.   | R 000   |  |
| R 125  | 4701.5 BACKGROUND CHECK REQUIREMENT<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on interview and review of personnel records, the Group Home for Persons with Mental Retardation (GHMRP), prior to employing an unlicensed person, failed to obtain a criminal background check for all jurisdictions in which the employee had worked or resided within the 7 years prior to the check, for 1 out of 1 qualified mental retardation professionals (QMRP) employed by the facility.<br><br>The finding includes:<br><br>On 6/24/2010, at approximately 8:45 a.m., interview with the QMRP revealed that he began serving in that position in the facility in September 2009. Beginning at 12:45 p.m., review of his | R 125   | The Qmrp's criminal background record is currently on file<br>Refer to attachment #9<br>In the future, the HR department will ensure that all employees files are up to date, and that the record are available upon request.<br><br>6-30-10 |

Health Regulation Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
STATE FORM

TITLE  
CSD

(X8) DATE  
7/10/10

Health Regulation Administration

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| R 125  | <p>Continued From page 1</p> <p>personnel record revealed no evidence that a background check had been obtained. At 1:30 p.m., the QMRP indicated that an investigator made a similar request a few weeks earlier. He stated that he would have someone bring his background check to the facility from the corporate office. At 3:25 p.m., review of additional information that was presented revealed the following:</p> <ol style="list-style-type: none"> <li>On 1/22/2010, four months after his date of hire in September 2009, the QMRP requested a background check through the Maryland Department of Public Safety and Correctional Services. There was no evidence that a background check was sought prior to his employment.</li> <li>A letter from the Maryland Department of Public Safety and Correctional Services, dated 1/25/2010, indicated that the results of the QMRP's 1/22/2010 request for a nationwide criminal history check through the FBI were "pending ... you will be notified by mail when the results have been received." As of 6/24/2010, there was no evidence that the facility determined the findings or results of the FBI search.</li> <li>The QMRP's employment application form indicated that he had worked in Virginia from 1994 - 2008. The facility documented a nationwide search was conducted by a private agency on 5/27/2010, at 3:45 p.m.</li> </ol> | R 125   | <p>The Qmrp's criminal background record is currently on file 6-30-10<br/>Refer to attachment #9<br/>In the future, the HR department will ensure that all employees files are up to date, and that the record are available upon request.<br/>The Qmrp's criminal background record is currently on file 6-30-10<br/>Refer to attachment #9<br/>In the future, the HR department will ensure that all employees files are up to date, and that the record are available upon request.<br/>The Qmrp's criminal background record is currently on file 6-30-10<br/>Refer to attachment #9<br/>In the future, the HR department will ensure that all employees files are up to date, and that the record are available upon request.</p> | 6-30-10<br>6-30-10<br>6-30-10 |

Health Regulation Administration

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| 1 000   | INITIAL COMMENTS<br><br>A licensure survey was conducted from 6/23/2010 through 6/24/2010. A sample of two residents was selected from a population of three men with various degrees of cognitive and intellectual disabilities.<br><br>The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.   | 1 000   |  |  |
| 1 040   | 3502.1 MEAL SERVICE / DINING AREAS<br><br>Each GHMRP shall provide each resident with a nourishing, well-balanced diet.<br><br>This Statute is not met as evidenced by:<br>Based on observation, the Group Home for Persons with Mental Retardation (GHMRP) failed to offer a food substitution to ensure provision of a nourishing, well-balance diet, for one of the two residents in the sample. (Resident #1)<br><br>The finding includes:<br><br>On 6/23/2010, dinner was served at 5:11 p.m. Resident #1 and his two housemates were served the following food items family style: quiche, brussels sprouts, rice, apple juice and water. At 5:34 p.m., Resident #1 stood up from the table and carried his plate to the kitchen. Although he had eaten most of his rice and quiche, he threw away all 8 of the brussels sprouts that he had been served. Two staff were present during the meal and did not ask about his vegetables. Staff observed him discard the brussels sprouts and did not offer him an | 1 040   | All staff were trained by the nurse and QMRP on the appropriate substitution to ensure proper nutrition.<br><br>The emphasis was on the emphasis was on mealtime protocol, opportunity for choice and self management.<br><br>Refer to attachment #3<br><br>In the future the facility will ensure that the clients are given the opportunity to make choices during mealtime. | 7-08-10                                      |

Health Regulation Administration

LABORATORY BUILDING FOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
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Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0178</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>06/24/2010</b> |
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| I 040  | Continued From page 1<br><br>appropriate substitution when he returned to the table. Moments later, he and his peers ate dessert (sugar-free vanilla pudding) and the meal ended.  | I 040   |  |   |
| I 082  | <b>3503.10 BEDROOMS AND BATHROOMS</b><br><br>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to equip all bathrooms used by residents with toilet tissue and paper cups, for three of the three residents of the facility. (Residents #1, #2 and #3)<br><br>The findings include:<br><br>1. On 6/23/2010, at approximately 6:55 a.m., interview with Resident #2 and two direct support staff revealed that the resident did not attend day program due to medical issues. The resident remained in the facility that morning after his peers.<br><br>At 10:35 a.m., observation revealed that there was no toilet tissue in the bathroom located on the main floor. Moments later, observations in the bathrooms located in the basement and on the second floor revealed that there was no toilet tissue available for use in either one. [Note: There were no other bathrooms in the facility.] At 10:40 a.m., a direct support staff person stated that she was without a key to unlock a storage | I 082   | All staff were inserviced on the house keeping by the house manager, and on the infection control by the nurse on 7-08-10<br>Refer to attachment #9 (a &b)<br>In the future, the facility management will ensure that ample quantities of all necessary supplies ( hand soap, cup dispenser, paper towel, bathroom tissue) are present in the house, and available for use by the clients and staff at all time. |   |

Health Regulation Administration

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| I 082  | Continued From page 2<br><br>room; therefore, she would telephone someone outside the facility. There was no evidence that the facility established and implemented a system to ensure continuous availability of toilet tissue for Resident #2 and staff working in the GHMRP during the day.<br><br>2. Observation and interview with the facility's house manager during the environmental inspection on 6/24/2010, at approximately 1:30 p.m., revealed the bathroom in the hallway on the second floor was without a cup dispenser. Interview with the facility's qualified mental retardation professional (QMRP) on the same day at approximately 1:32 p.m. revealed they planned to address that oversight immediately.<br><br>This is a repeat deficiency.<br><br>Previously, the licensure deficiency report dated 5/21/2009, included the following:<br><br>The environmental inspection on 5/20/2009, at 9:25 a.m., revealed neither Bathroom #1 on the first floor nor Bathroom #2 on the second floor was equipped with a cup dispenser for the resident's use. Interview with the facility's house manager on the same day at approximately 9:50 a.m. revealed he would address the oversight with the maintenance staff. | I 082   | All staff were inserviced on the house keeping by the house manager, and on the infection control by the nurse on<br>Refer to attachment #9 (a &b)<br>In the future, the facility management will ensure that ample quantities of all necessary supplies ( hand soap, cup dispenser, paper towel, bathroom tissue) are present in the house, and available for use by the clients and staff at all time. | 7-08-10            |   |
| I 090  | 3504.1 HOUSEKEEPING<br><br>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.  | I 090   |  |                    |   |

Health Regulation Administration

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| I 090  | Continued From page 3<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the proper maintenance of the facility's environment, for three of the three residents in the facility. (Residents #1, #2, #3)<br><br>The findings include:<br><br>During the environmental inspection on 6/24/2010, at approximately 1:45 p.m., the following deficient practices were identified:<br><br>1. Three large garbage bins of old carpets, wood boards and various other items were being stored along the walkway below the deck.<br><br>2. An old broken bathroom vanity cabinet and porcelain sink with the metal plumbing attached was also found under the walkway below the deck.<br><br>3. Old rusted wheelchairs were also observed being stored along the walkway below the deck.<br><br>This is a repeat deficiency.<br><br>Previously, the licensure deficiency report dated 5/21/2009, included the following:<br><br>Based on observation and staff interview on 5/20/2009, at approximately 9:35 a.m., the facility failed to ensure the upkeep and maintenance of the exterior of the facility as evidenced below: | I 090   | 1. All of the garbage will be picked up by Bulk trash company on<br>In the future, the facility management will ensure that the environment is maintained in in a safe and sanitary manner, and free of the accumulation of dirt, and rubbish.<br>2. The old broken bathroom vanity cabinet porcelain sink will be removed on<br>In the future, the facility management will ensure that the environment is maintained in in a safe and sanitary manner, and free of the accumulation of dirt, and rubbish.<br>3. the rusted wheelchair will be removed on<br>In the future, the facility management will ensure that the environment is maintained in in a safe and sanitary manner, and free of the accumulation of dirt, and rubbish. | 7-27-10<br><br>7-19-10<br><br>7-19-10               |

Health Regulation Administration

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| I 090  | Continued From page 4<br><br>"5. The trash area under the deck near the front of the facility was overflowed with old building materials, boxes, garbage, wheelchairs, and pipes."  | I 090   |  |   |
| I 183  | 3508.4 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the qualified mental retardation professional (QMRP) employed by the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning, for two of the two sampled residents. (Residents #1 and #2)<br><br>The findings include:<br><br>1. The QMRP failed to ensure outside services consistently monitored Resident #1's progress when there was a failure to progress. [See Federal Deficiency Report - Citation W120]<br><br>2. The QMRP failed to ensure that staff ensured resident choice during meals. [See Federal Deficiency Report - Citation W247]<br><br>3. The QMRP failed to ensure the accurate and consistent documentation of Resident #1's habilitation program. [See Federal Deficiency Report - Citation W252]<br><br>4. The QMRP failed to ensure the human rights committee reviewed, monitored, and approved Resident #1's revised behavior support plan. | I 183   | 1. Refer to W 120 P. 1 of 14 Attachment # 1<br>2. Refer to Refer to W 247 P. 5 of 14 Attachment #3<br>3. Refer to W 252 P. 5&6 of 14 Attachment #4<br>4. Refer to W 262 P. 7&8 of 14 Refer to attachment # 5 (a, b, c) | 7-15-10<br>7-8-10<br>7-8-10                         |



Health Regulation Administration

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| I 500  | Continued From page 6<br><br>protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation.<br><br>The finding includes:<br><br>The facility failed to demonstrate protection of residents' rights to have their parent notified in writing whenever an instance of neglect occurred. [Title 7, Chapter 13, § 7-1305.10(f), formerly § 6-1970(f)] as follows:<br><br>On 6/23/2010, beginning at 12:40 p.m., review of incident reports and investigations in the facility revealed that an allegation of staff neglect was made on 5/12/2010. The incident report indicated that a direct support staff person left the three residents unattended in the facility for an unknown length of time. Further review of the incident report and related documents failed to show evidence that the residents' family members and guardians had been notified. Beginning at 2:00 p.m., interview with the facility's incident management coordinator (IMC) revealed that the qualified mental retardation professional (QMRP) was thought to have telephoned the guardians and families. After reviewing the incident report and corresponding investigation report (dated 5/17/2010), however, the IMC acknowledged that notification of family members | I 500   | It is RCM policy to notify the clients' family members, and guardians each time an incident occurs. This notification is usually documented on the incident report. In this case, the QMRP, and IMC failed to document this information on the body of the incident report form prior to sending the report to different entities. The program Director did address this issue with the QMRP and IMC on<br><br>See attachment # 2<br><br>In the future, the Qmrp will ensure that the families members and guardians are notified when an incident occurs; additionally, due to the time sensitivity of certain reports, a revised and complete copy of the incident report will be generated, and sent to different entities. Family members and guardians with email addresses will be notified electronically as well. | 6-25-10.  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0178</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/24/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>R C M OF WASHINGTON</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4316 ALABAMA AVE, SE<br/>WASHINGTON, DC 20019</b> |   |   |
| (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  | Continued From page 7<br><br>and guardians had not been documented. When asked if anything had been sent to the families/guardians in writing, the IMC deferred to the QMRP.<br><br>The QMRP was interviewed on 6/24/2010, at approximately 8:50 a.m. He stated that he had notified the family members by telephone. He stated that usually such notifications were documented on the initial incident report. However, after examining the 5/12/2010 incident report, he acknowledged that the telephone calls had not been documented, for reasons not known. When asked if anything had been sent to the families/guardians in writing, the QMRP indicated no, unless the IMC had sent written notifications.<br><br>It should be noted that the staff person in question had admitted to leaving the residents unattended. The facility subsequently terminated his employment due to the finding of neglect. | I 500   | It is RCM policy to notify the clients' family members, and guardians each time an incident occurs. This notification is usually documented on the incident report. In this case, the QMRP, and IMC failed to document this information on the body of the incident report form prior to sending the report to different entities. The program Director did address this issue with the QMRP and IMC on<br><br>See attachment # 2<br><br>In the future, the Qmrp will ensure that the families members and guardians are notified when an incident occurs; additionally, due to the time sensitivity of certain reports, a revised and complete copy of the incident report will be generated, and sent to different entities. Family members and guardians with email addresses will be notified electronically as well. | 6-25-10.  |