

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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2009
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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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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from July 29, 2009 through July 31, 2009. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a client population of four males with various disabilities. A focused review of another (third) client's frequent incidents was conducted as well.</p> <p>The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports.</p>	W 000	<p>It is the policy of this provider that privacy is ensured during the medication administration. On July 29, 2009 the medication nurse failed to ensure privacy while administrating the medication. The medication nurse was in-serviced by the charge nurse on Refer to attachment #1 In the future the nursing team will ensure that client #4 is given privacy during the administration of his medication.</p>	8-12-09
W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during the administration of medications for two of four clients in the facility. (Client #1 and Client #4)</p> <p>The findings include:</p> <p>1. On July 29, 2009, at approximately 8:10 PM, the Licensed Practical Nurse (LPN) was observed to apply Mycocide NS Solution to all of Client #4's toenails while Client #1 sat on a sofa on the opposite side of the living room. In an interview with the LPN on July 29, 2009 at approximately 8:35 PM, it was acknowledged Client #4 was not provided privacy during the application of</p>	W 130	<p><i>Revised 8/18/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angele Spamba</i>	TITLE <i>Program Director</i>	(X6) DATE <i>8-17-09</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 medication to his toenails. There was no evidence that Client #4 was ensured privacy during the administration of his medication. 2. On July 29, 2009, at approximately 8:12 PM, the LPN was observed to apply Mycocide NS Solution to all of Client #1's toenails while Client #4 sat on a chair near the television on the opposite side of the living room. In an interview with the LPN on July 29, 2009, at approximately 8:36 PM, acknowledged Client #1 was not provided privacy during the application of medication to his toenails. There was no evidence that Client #1 was ensured privacy during the administration of his medication.	W 130	It is the policy of this provider that privacy is ensured during the medication administration. On July 29, 2009 the medication nurse failed to ensure privacy while administering the medication. The medication nurse was in-serviced by the charge nurse on Refer to attachment #1 In the future the nursing team will ensure that client #1 is given privacy during the administration of his medication.	8-12-09
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its established policy on Vehicle Safety for one of two clients included in the sample. (Client # 1) The finding includes: Cross refer to W193. On July 29, 2009, at 5:38 PM, Client #1 returned home from a community outing with his 1:1 staff. The 1:1 staff (driver) was observed to get out the driver's seat walk over an	W 149		

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W 149	<p>Continued From page 2</p> <p>assist Client #1 in getting out of the passenger seat. An earlier interview with the Assistant House Manager at approximately 5:00 PM revealed that Client #1 was taken on a community outing to avoid going into maladaptive behaviors caused by his housemate.</p> <p>Interview with the House Manager (HM) on July 31, 2009, at approximately 3:00 PM, revealed that there should always be two staff on the facility's van when transporting clients on medical appointments and/or community outings.</p> <p>Review of the Vehicle Safety Policy dated May 1, 2009 revealed "there will be one or more attendants in the van to ensure that the individuals are monitored to prevent injuries, and to address behavior management when transporting medically fragile/behavioral individuals in and out of the van during medical appointments, or other during other activities."</p> <p>There was no evidence the facility implemented its established policy on Vehicle Safety when transporting behavioral clients on community outings.</p>	W 149	<p>This provider has a Vehicle Safety Policy that indicates that there must always have one or more attendants when transporting medically fragile/behavior management in and out of the van, during medical appointments, or other activities. All staff were in re-serviced by the Program Director on</p> <p>Refer to attachment #2</p> <p>In the future the facility team will ensure that there are always have one or more attendants when transporting medically fragile/behavior management in and out of the van, during medical appointments, or other activities.</p>	8-12-09	
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation</p>	W 159			

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W 159	<p>Continued From page 3</p> <p>Professional (QMRP) for four of four clients residing in the facility. (Client #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure that Client #1 received an assessment to determine his adaptive feeding equipment as evidenced below.</p> <p>Observations on July 29, 2009, at 3:24 PM revealed Client #1 eating chocolate pudding with a built up spoon. Further observations during dinner at 6:20 PM revealed Client #1 eating turkey, stuffing and mix vegetables utilizing a Hi-lo plate and a built up spoon.</p> <p>On July 30, 2009, at 3:00 PM, review of the Client #1's current Physician's Orders dated July 2009 revealed there were no orders for the hi-lo plate and built up spoon. On July 31, 2009, review of the Occupational Therapy and Speech and Language Assessment also revealed no recommendation for Client #1's Hi-lo plate and built up spoon.</p> <p>Interview with the QMRP on July 31, 2009, at approximately 3:00 PM revealed that when Client #1 was transferred to this facility, the aforementioned adaptive equipment accompanied him and was continued. At the time of the survey, there was no evidence that client #1 had been reassessed for the continued need for his adaptive equipment. Further interview with the QMRP confirmed that an assessment had not been completed.</p> <p>2. Cross refer W189. The QMRP failed to ensure that each employee had been provided</p>	W 159	<p>Client # 1 has an OT assessment that notes that he must be using a built up spoon as mealtime adaptive equipment. Staff provided client #1 with a Hi-lo plate plate which was not prescribed by the Occupational Therapist. The use of the Hi-lo plate was discontinued sometimes ago.</p> <p>All staff were in serviced on the adaptive equipment on</p> <p>Refer to attachment #3</p> <p>In the future the Qmrp will ensure that the use use the adaptive equipment as prescribed.</p>	8-13-09
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W 159	Continued From page 4 with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. 3. Cross refer W252. The QMRP failed to ensure the facility to document behavior data in accordance with the Behavior Support Plan. 4. Cross refer W193. The QMRP failed to ensure staff demonstrated competency in the implementation of the behavior support plans. 5. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See W440]	W 159	Refer to W 252 P. 8 Attachment # Refer to W 193 P.P.7&9 Attachment # 7 Refer to W 440 P.12 Attachment #9 All staff were in serviced on the helmet protocol on Refer to attachment #4 In the future, the Qmrp will ensure that the staff implement client #1's helmet protocol as prescribed by the PT	8-12-09 8-12-09 8-12-09 8-12-09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for two of two clients in the facility. (Client #1) The findings include: 1. The facility failed to ensure that the direct care staff implemented Client #1's helmet protocol as recommended by the Physical Therapist. On July 29, 2009, at 3:34 PM, the 1:1 staff was	W 189		

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W 189	<p>Continued From page 5</p> <p>observed to take Client #1's helmet off his head. Further observation revealed the 1:1 staff assisting Client #1 to the kitchen for a snack.</p> <p>Record review conducted on July 31, 2009, at 11:20 AM, revealed a Helmet Protocol dated May 4, 2009. According to the protocol, Client #1 "should be allowed to remove his helmet while sitting at home". Further review revealed Client #1 "should wear the helmet while he is awake and ambulating". Review of the staff in-service training book on July 31, 2009, at approximately 10:45 AM, revealed that all staff had received training on Client #1's Helmet protocol on May 4, 2009. There was no evidence that the training had been effective.</p> <p>2. The facility failed to ensure that the direct care staff encouraged Client #1 to slow down while eating as recommended by the nutritionist.</p> <p>Observation on July 17, 2009, at 6:20 PM, revealed Client #1 eating turkey, stuffing and mix vegetables at a rapid pace.</p> <p>Record review conducted on July 30, 2009, at 4:12 PM, revealed a Nutrition Assessment dated April 25, 2009. According to the recommendation, Client #1 required encouragement from staff to slow his eating pace by resting the spoon on the side of the plate and sip beverages between bites. Review of the staff in-service training book on July 31, 2009, at approximately 10:00 AM, revealed that all staff had received training on Client #1's eating protocol. There was no evidence that the training had been effective.</p> <p>3. Cross Refer to W 455. The facility failed to</p>	W 189	<p>All staff were inserviced on the helmet protocol on</p> <p>Refer to attachment #4</p> <p>In the future, the Qmrp will ensure that the staff implement client #1's helmet protocol as prescribed by the PT</p> <p>All staff were re-inserviced on client #1's eating protocol.</p> <p>Refer to attachment #5</p> <p>In the future, the management team will ensure that the staff implement client #1 eating protocol during mealtime.</p> <p>Refer to W 455 P. 12</p>	<p>8-12-09</p> <p>8-12-09</p> <p>8-12-09</p>

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W 189	Continued From page 6 provide effective, efficient, and competent training for the prevention and control of infection and communicable diseases for one of one staff in the facility. (LPN #1)	W 189	Refer to W 455 P. 12 Attachment # All staff were inserviced on client #1' I:I protocol. The protocol spells that the one on one staff should remain in close proximity of client #1.	8-12-09	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate competency in the implementation of client's Behavior Support Plan (BSP) for one of four clients included in the sample. (Client #1) The finding includes: The facility failed to ensure that Client #1's 1:1 staff remained in close proximity in accordance with his BSP as evidence below: On July 29, 2009, at 5:38 PM, Client #1 returned home from a community outing with his 1:1 Staff. The 1:1 staff (driver) was observed to get out the driver's seat walk over an assist Client #1 in getting out of the passenger seat. No other clients and/or staff was observed to exit the facility's vehicle. An earlier interview with the Assistant House Manager at approximately 5:00 PM revealed that Client #1 was taken on a community outing to avoid going into maladaptive behaviors caused by his housemate. Interview with the Qualified Mental Retardation Professional (QMRP) on July 31, 2009, at approximately 1:50 PM revealed that Client #1	W 193	Refer to attachment #6 In the future, the management will ensure that the staff implement client #1's behavior support plan as written.	8-12-09	

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W 193	Continued From page 7 received 1:1 staffing 24 hours a day to manage physical safety maladaptive behaviors. (i.e. hitting, kicking, spitting, biting, deliberately striking himself about the neck, striking his head or limbs on hard surfaces, striking himself with hard items, striking himself on and about the eyes, picking his skin to deliberately cause bleeding, attempting to break windows/doors, angry cursing, name calling, screaming, and threats to others) Further interview revealed that Client #1 was prescribed a "soft helmet" for seizures and head banging. On June 31, 2009, at 2:00 PM, review of Client 1#'s Psychological Assessment dated April 24, 2009 confirmed the QMRPs' interview. There was no evidence that on June 29, 2008, the facility staff demonstrated competency in the implementation of the client's BSP.	W 193	All were inserviced on client #1' 1:1 protocol. The protocol spells that the one on one staff should remain in close proximity of client #1. Refer to attachment #6 In the future, the management will ensure the staff implement client #1's behavior support plan as written. All staff were inserviced by the Behavior Specialist on the data collection sheets prior to medical appointments on 7-30-09 Another training was completed by the Charge Nurse on Refer to attachment #7 In the future, the facility management will ensure that staff/nurses complete the data sheets prior to or before his medical appointments.	8-12-09	
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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to document behavior data in accordance with the Behavior Support Plans (BSP), for one of two clients in the sample. (Clients #2) The finding includes: The facility failed to ensure staff/nurse's completed Client #2's data collection sheets prior to or before his medical appointments as evidenced below:	W 252			

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W 252	<p>Continued From page 8</p> <p>On July 30, 2009, at 2:58 PM, interview with the designated Licensed Practical Nurse (LPN) and review of Client #2's medical book revealed the client received sedation (Xanax) for the following medical appointments: a) .25 mg prior to labs on 1/8/09, b) 1 mg prior to ultrasound on 2/25/09, c) .5 mg prior to podiatry on 3/17/09, d) 1 mg prior to ultrasound on 5/8/09, and e) .5 mg prior to podiatry on 7/17/09. Further interview with the LPN revealed that Client #2 had a medical BSP in place to address his medical procedures.</p> <p>On July 30, 2009, at 4:10 PM, review of the Client #2's BSP dated July 2009, revealed the following note: "Since this plan addresses an issue related to Client #2's health and maintenance, data on this program are collected by residential staff with the support of the nurse. The nurse must be always notified by staff members and clinical personnel at the medical site of Client #2's cooperation, resistance, or a request that he return only after an anxiolytic has been administered." Further review of the BSP revealed the nurse and a staff must complete the data sheets provided for EACH medical or dental appointment.</p> <p>Review of the ABC behavior data collection sheets on July 31, 2009, at approximately 9:45 AM revealed that staff and/or the nurse had not completed Client #2's data sheets in accordance with the BSP.</p> <p>Interview with the LPN again on July 31, 2009, at 10:00 AM acknowledged that she had not collected data on the data sheets for the aforementioned sedation listed above. The LPN stated that, "it's my fault if it's not there. I should</p>	W 252	<p>All staff were inserviced by the Behavior Specialist on client #2's the data collection sheets prior to medical appointments on 7-30-09 Another training was completed by the Charge Nurse on Refer to attachment #7 In the future, the facility management will ensure that staff/nurses complete client #2's the data sheets prior to or before his medical appointments.</p> <p>All staff were inserviced by the Behavior Specialist on client #2's the data collection sheets prior to medical appointments on 7-30-09 Another training was completed by the Charge Nurse on Refer to attachment #7 In the future, the facility management will ensure that staff/nurses complete client #2's the data sheets prior to or before his medical appointments.</p>	8-12-09	8-12-09

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W 252	Continued From page 9 have fill out the documentation sheets before/after Client #2 medical appointments." During the exit conference on July 31, 2009, at approximately 4:15 PM, the LPN stated that she was not sure about how or when to fill out the data sheets for Client #2's medical appointments that involved sedation. The LPN further stated that all staff including nurses received initial training on how to correctly fill out the data sheets for Client #2 on July 31, 2009 during the House Meeting earlier that morning.	W 252	All staff were inserviced by the Behavior Specialist on client #2's the data collection sheets prior to medical appointments on 7-30-09 Another training was completed by the Charge Nurse on Refer to attachment #7 In the future, the facility management will ensure that staff/nurses complete client #2's the data sheets prior to or before his medical appointments.	8-12-09	
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of three clients included in the sample. (Client #1) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Client #1's physician's order (PO) from October 2008 to July 2009 on July 30, 2009, at approximately 3:00 PM, revealed an order for the client to have laboratory studies for Serum Amylase every six months. There was no evidence of laboratory studies for Serum Amylase from October 2008 to July 2009.	W 325	The nursing staff sent the individual for his biannual lab that the PCP did not draw the Amylase. The nursing staff addressed the need to comply with the Psychiatrist's order, and the PA agreed. The PA has drawn client #1 Amylase on	8-10-09	

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W 325	Continued From page 10	W 325		
W 331	<p>Interview with the License Practical Nurse (LPN) on July 30, 2009, at approximately 3:30 PM, confirmed that the laboratory studies were not completed as ordered.</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for two of four clients in the facility. (Clients #1 and #4)</p> <p>The finding includes:</p> <p>Cross Refer to W130. The facility's nursing staff failed to ensure privacy during the administration of medications for two of four clients in the facility. (Client #1 and #4)</p>	W 331	Refer to W 130 P. 1 Attachment # 1	8-12-09
W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts of drills reviewed.</p> <p>The finding includes:</p>	W 440		

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

PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2009
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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W 440	Continued From page 11 Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2009, at 12:30 revealed the facility had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. Review of the fire drill reports from August 2008 to July 2009 was conducted on July 30, 2009, at 12:31 PM. Further review of the fire drill reports from February 2009 to April 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM and 12 AM to 8 AM shifts during the week. Interview with the QMRP on July 31, 2009, at approximately 2:00 PM acknowledged that fire drills were not in the fire drill log book for this period. At approximately 3:00 PM, the QMRP presented the surveyor with fire drills during the aforementioned period that was scanned on the computer. The drills did not have all required signatures for approval. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	W 440	All staff were inserviced on Fire Safety, including fire drills and evacuation drills, the scheduling, and form completion. Refer to attachment #9 In the future, the facility management will ensure that the drills are completed as scheduled, and the forms are filled completely; additionally, all of the drill records must be filled in the fire drills books. In the future, the facility will ensure that all of the drills are completed as scheduled, and that the forms are completed, filled, and available upon request.	8-12-09
W 455	483.470(I)(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 and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of two clients included in the sample. (Client #1) The finding includes:	W 455		

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W 455	<p>Continued From page 12</p> <p>During medication administration observation on July 29, 2009, at approximately 7:50 PM, Staff #1 was not observed to wash his hands. Staff #1 held an unwrapped drinking straw in his bare hand and then placed the aforementioned straw into Client #1's glass of water. Further observation revealed Client #1 sipped water from the straw. In an interview with LPN #1 and Staff #1 on July 29, 2009, at approximately 8:00 PM, it was acknowledged Staff #1 placed the drinking straw that he held in his bare hand into Client #1's glass of water.</p> <p>There is no evidence that the facility's staff provided an active program for the prevention and control of infection.</p>	W 455	<p>All staff were inserviced by the charge nurse on the infection control on Refer to attachment #10</p> <p>In the future the facility management will ensure that the staff is provided with an active program for the prevention of the infection control.</p>	8-12-09

Health Regulation 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 07/31/2009
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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I 000	INITIAL COMMENTS A licensure survey was conducted from July 29, 2009 through July 31, 2009. A random sample of two residents was selected from a client population of four males with various disabilities. A focused review of another (third) resident's frequent incidents was conducted as well. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports.	I 000		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHRMP failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts of drills reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2009, at 12:30 revealed the GHRMP had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. Review of the fire drill reports from August 2008 to July 2009 was conducted on July 30, 2009, at 12:31 PM. Further review of the fire drill reports	I 135	All staff were inserviced on Fire Safety, including fire drills and evacuation drills, the scheduling, and form completion. Refer to attachment #9 In the future, the facility management will ensure that the drills are completed as scheduled, and the forms are filled completely; additionally, all of the drill records must be filled in the fire drills books. In the future, the facility will ensure that all of the drills are completed as scheduled, and that the forms are completed, filled, and available upon request.	8-12-09

Health Regulation Administration

Angelo E. ...
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director
TITLE

(X6) DATE
8-17-09

Health Regulation Administration

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I 135	Continued From page 1 from February 2009 to April 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM and 12 AM to 8 AM shifts during the week. Interview with the QMRP on July 31, 2009, at approximately 2:00 PM acknowledged that fire drills were not in the fire drill log book for this period. At approximately 3:00 PM, the QMRP presented the surveyor with fire drills during the aforementioned period that was scanned on the computer. The drills did not have all required signatures for approval. At the time of the survey, the GHMRP failed to provide evidence of fire drills conducted quarterly as required.	I 135	All staff were inserviced on Fire Safety, including fire drills and evacuation drills, the scheduling, and form completion. Refer to attachment #9 In the future, the facility management will ensure that the drills are completed as scheduled, and the forms are filled completely; additionally, all of the drill records must be filled in the fire drills books. In the future, the facility will ensure that all of the drills are completed as scheduled, and that the forms are completed, filled, and available upon request.	8-12-09
I 136	3505.6 FIRE SAFETY Each GHMRP shall maintain records of each simulated fire drill. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure fire drills records were monitored and accurately completed for four of the twelve months reviewed. The finding includes: See Federal Deficiency Report - Citation W440	I 136	Refer to W 440 PP 11 & 12 Attachment # 8	8-12-09
I 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	I 206		

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I 206	Continued From page 2 duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with state regulations pertaining to health (22DCMR 35, section 3509.6) for three of ten consultants. The finding includes: The State regulatory agency conducted a review of personnel records on July 31, 2009, at approximately 12:00 PM, at which that time, there was no evidence of current health certificates on file for three of the ten consultants. (Consultants #1, #2, and #3) Interview with the Qualified Mental Retardation Professional (QMRP) on July 31, 2009 at 3:30 PM confirmed the missing health certificates were not available.	I 206	The Speech and Language Pathologist's Health Certificate is currently on file. Refer to attachment #11 The Behavioral Specialist and Occupational Therapy's health certificates will be on file In the future, the provider will ensure that all of the consultants records are up to date, and available upon request. All staff were inserviced by the charge nurse on the infection control on Refer to attachment #10 In the future the facility management will ensure that the staff is provided with an active program for the prevention of the infection control.	8-30-09 8-12-09
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for one of one staff. (Staff #1) The finding includes:	I 226		

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I 226	Continued From page 3 During medication administration observation on July 29, 2009, at approximately 7:50 PM, Staff #1 was not observed to wash his hands. Staff #1 held an unwrapped drinking straw in his bare hand and then placed the aforementioned straw into Resident #1's glass of water. Further observation revealed Resident #1 sipped water from the straw. In an interview with LPN #1 and Staff #1 on July 29, 2009, at approximately 8:00 PM, it was acknowledged Staff #1 placed the drinking straw that he held in his bare hand into Resident #1's glass of water. There is no evidence that the facility's staff demonstrated effective training on infection control.	I 226	All staff were inserviced by the charge nurse on the infection control on Refer to attachment #10 In the future the facility management will ensure that the staff is provided with an active program for the prevention of the infection control.	8-12-09
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 GHMRP failed to ensure three of twelve direct care staffs were certified to provide cardiopulmonary (CPR) for four of four residents residing in the GHMRP. (Residents #1, #2, #3, and #4) The finding includes:	I 227	Staff # 1,2,3 did take the CPR and and First Aid class on In the future, the provider will ensure that all staff are trained in the areas that will allow them to perform their duties.	8-15-09

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I 227	Continued From page 4 On July 31, 2009 beginning at 11:25 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed there was no documented evidence of current CPR certification training for three of twelve staffs who had been employed for longer than 90 days. (Staffs #1, #2, and #3)	I 227	Staff # 1,2,3 did take the CPR and and First Aid class on In the future, the provider will ensure that all staff are trained in the areas that will allow them to perform their duties	8-15-09