PRINTED: 07/24/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G217		07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(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
W 000	INITIAL COMMENTS An initial recertification survey was conducted from July 10, 2008 through July 11, 2008 using the full survey process. Two male clients with mental retardation and developmental disabilities resides in the facility and was chosen as the sample. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of two clients residing in the facility. (Client #2) The finding includes: During the medication pass on July 10, 2008 at 5:57 PM, Client #2 was administered Risperdal 1 mg by mouth. Interview with the facility's	W 124		

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ADMINISTRATION
2008 JUL 29 P 4: 37

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Bianka TITLE: Program Director (X6) DATE: 7-28-08

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 124	Continued From page 1 Registered Nurse (RN) revealed that the medication was prescribed for maladaptive behaviors. Review of the client's current physicians orders on July 10, 2008 at approximately 1:53 PM revealed that the psychotropic medications was incorporated in a Behavior Support Plan (BSP) dated June 30, 2008, to address behaviors associated with mild physical aggression (deliberately pushing or hitting staff and peers). Interview with the facility's Chief Operations Officer (COO) on July 10, 2008 at approximately 4:00 PM revealed that Client #2 has a legal guardian. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that she had forward all consent forms to be signed to Client #2's legal guardian P.O. Box. Review of Client #2's Psychological Assessment dated April 12, 2008 on July 11, 2008 AM revealed that the client did not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, treatment placement, financial, and medical matters. There was no documented evidence that the facility informed Client #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	All of the consent forms were given to individual # 2 Legal Guardian for signature. However, the legal guardian failed to return the signed forms in spite of many attempts made by the Qmrp to contact him. Refer to attachment #1 In the future, the provider will ensure that the legal guardian is informed of all the health benefits and risk of treatment associated with the use of his psychotropic medication and corresponding BSP. The legal guardian will be informed on all the individual #2 well being including medical condition, developmental, and behaviors status.	7-24-08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 2	W 159		
	This STANDARD is not met as evidenced by: Based on interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen.			
	The findings include:		All of the Individual # 2 adaptive equipment were ordered.	7-24-08
	1. The QMRP failed to ensure necessary adaptive equipment was furnished for Client #2. [See W436]		In the future the facility will ensure that all of the individual adaptive equipments are available in the facility.	
	2. The QMRP failed to ensure that clients received continuous active treatment services for client #2. [Refer to W249]		Individual #2 home management Goal/objective and IPP is in place, and the staff will be inserviced Refer to attachment # 2. In the future the qmrp will ensure the the goals are implemented timely to ensure the contineous active treatment.	7-28-08
	3. The QMRP failed to ensure that staff were provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. [See to W189]		All staff will be inserviced/trained on individual # 2 IPP objective.	7-28-08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		
	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.			

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W 189	Continued From page 3 The findings include: The facility failed to ensure that staff had received effective training on implementing Client #2's Individual Program Plan objective. [See W249]	W 189		
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 observations, interview and record review, the facility failed to ensure Client #2 received continuous active treatment services. The finding includes: On July 10, 2008 at approximately 6:19 PM, direct care staff was observed wiping off the dining room table after Client #2 had completed his dinner meal. At no time did staff encourage Client #2 to wipe off the table after completing the dinner meal. Interview with the direct care staff on July 10, 2008 revealed that Client #2 had an objective to wipe off the table after dinner with assistance. Review of Client #2's Individual Program Plan (IPP) dated June 26, 2008 on July 11, 2008 at 9:18 AM revealed a program that stated "the client will wipe the table after dinner with physical	W 249	Individual #2 home management Goal/objective and IPP is in place, and the staff will be inserviced Refer to attachment # 2. In the future tha qmrp will ensure the goasl are implemented timely to ensure the contineous active treatment.	7-28-08

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W 249	Continued From page 4 assistance from staff on 80% recorded trails per month for three consecutive months. Review of the staff in service training records on July 11, 2008 revealed that staffs had received training on implementing Client #2's program objectives on June 14, 2008. There was no evidence that training had been effective.	W 249	Individual #2 home management Goal/objective and IPP is in place, and the staff will be inserviced Refer to attachment # 2. In the future tha qmrp will ensure the goals are implemented timely to ensure the contineous active treatment.	7-28-08
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for one of two clients included in the sample. (Client #2) The finding includes: The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Behavior Support Plan (BSP) that incorporated the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) revealed that Client #2 did not have written informed consent signed his by a guardian. [See W124]	W 263	All of the consent forms were given to individual # 2 Legal Guardian for signature. However, the legal guardian failed to return the signed forms in spite of many attempts made by the Qmrp to contact him. Refer to attachment #1 In the future, the provider will ensure that the legal guaridan is informed of all the health benefits and risk of treatment associated with the use of his psychotropic medication and corresponding BSP. The legal guardian will be informed on all the individual #2 well being including medical condition, developmental, and behaviors status.	7-24-08
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,	W 436		

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W 436	Continued From page 5 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 and interview, the facility failed to ensure necessary adaptive equipment was furnished for one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to ensure that Client #2 was provided with the recommended adaptive feeding equipment as evidenced below:	W 436		
	On July 10, 2008 at 11:41 AM, Client #2 was served chicken breast pattie, collard greens, and boiled potatoes from a scoop dish with a plate guard at his day program. Client #2 was observed to spill very little food while feeding. Observation of the dinner meal on the same day at approximately 6:02 PM revealed Client #2 ate from a regular plate with no plate guard. Direct care staff was observed throughout the dinner meal to push Client #2's food back to the middle of the plate using an additional spoon to avoid continued spillage.		Refer to W 159 P.3	7-24-08
	Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #2's plate guard was locked up in the dish washer with his previous provider. The QMRP indicated that they were not able to get back into the home in which Client #2 transitioned from to retrieve the plate guard. The QMRP further indicated that the		Refer to W 159 P.3	7-24-08

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W 436	Continued From page 6 facility had ordered another plate guard. Review of Client #2's record on July 10, 2008 at approximately 4:30 PM revealed an Occupational Therapist Assessment (OT) dated May 15, 2008. According to the OT assessment, Client #2 should continue to use his scoop dish while feeding.	W 436	Refer to W 159 P.3	7-24-08
W 454	483.470(i)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each staff prepared food in a sanitary conditions at all times. The finding includes: On July 10, 2008 at approximately 1:30 PM, a pack of meat was observed thawed out inside the sink. The meat remained in the sink until staff started preparing dinner at 4:30 PM (approximately 3 hours later. Interview with the House Manager revealed that the meat should have been taken out of the freezer a few minutes before dinner because the meat was not that thick. Further interview with the House Manager revealed that staff should have placed the meat inside the refrigerator after it had thawed out. There was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.	W 454	All staff were inserviced/trained on food preparation Refer to attachment #3 Several staff will attend the Food Handling Training Class. 8-04-08 In the future the management will ensure that the the facility maintains a sanitary environment to avoid sources and transmission of infection.	7-21-08

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I 000	INITIAL COMMENTS A follow up licensure survey was conducted from July 10, 2008 through July 11, 2008. Two male residents with various degrees of developmental disabilities resided in the facility and was chosen as the sample. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	I 000		
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure necessary adaptive equipment was furnished for one of the two residents included in the sample. (Resident #2) The finding includes: The facility failed to ensure that Resident #2 was provided with the recommended adaptive feeding equipment as evidenced below: On July 10, 2008 at 11:41 AM, Resident #2 was served chicken breast pattie, collard greens, and boiled potatoes from a scoop dish with a plate guard at his day program. Resident #2 was observed to spill very little food while feeding. Observation of the dinner meal on the same day at approximately 6:02 PM revealed Resident #2 ate from a regular plate with no plate guard.	I 052	Refer to W 159 P.3	7-24-08

Health Regulation Administration

Angela Bramlea

TITLE Program Director

(X6) DATE 7-28-08

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

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I 052	Continued From page 1 Direct care staff was observed throughout the dinner meal to push Resident #2's food back to the middle of the plate using an additional spoon to avoid continued spillage. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #2's plate guard was not transferred from his previous provider. The QMRP indicated that they were not able to get back into the home in which Resident #2 transitioned from to retrieve the plate guard. The QMRP further indicated that the facility had ordered another plate guard. Review of Resident #2's record on July 10, 2008 at approximately 4:30 PM revealed an Occupational Therapist Assessment (OT) dated May 15, 2008. According to the OT assessment, Resident #2 should continue to use his scoop dish while feeding.	I 052	Refer to W 159 P.3	7-24-08
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHRMP failed to ensure that each staff prepared food in a sanitary manner at all times. The finding includes: On July 10, 2008 at approximately 1:30 PM, a pack of meat was observed thawed out inside the sink. The meat remained in the sink until staff started preparing dinner at 4:30 PM	I 056		

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I 056	Continued From page 2 (approximately 3 hours later). Interview with the House Manager revealed that the meat should have been taken out of the freezer a few minutes before dinner because the meat was not that thick. Further interview with the House Manager revealed that staff should have placed the meat inside the refrigerator after it had thawed out. There was no evidence that the GHRMP prepared food consistently in a sanitary manner to avoid sources and transmission of infection.	I 056	All staff were inserviced/trained on food preparation Refer to attachment #3 Several staff will attend the Food Handling Training Class In the future the management will ensure that the the facility maintains a sanitary environment to avoid sources and transmission of infection.	7-21-08 8-04-08
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview revealed that the GHMRP failed to ensure that caustic agents were stored in a locked cabinet. The finding includes: During the environmental inspection on July 11, 2008 several caustic agents were observed underneath the cabinets located in the kitchen.	I 095	All staff were inserviced on the handling of caustic agents. Currently all of the caustic agents have been stored in the locked cabinet. Refer to attachment # 4. In the future the facility will ensure that all of the caustic agents are stored in the locked cabinet.	7-21-08
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees.	I 203		

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I 203	Continued From page 3	I 203		
	The findings include:			
	Review of the personnel files conducted on July 10, 2008 at 4:12 PM, revealed the GHMRP failed to provide evidence of current signed job descriptions for two staff at the time of the survey.		All of the personnel files will be updated by In the future the mamgement will ensure that all of the personnel files are updated, and that the information is availble upon request.	8-01-08
I 206	3509.6 PERSONNEL POLICIES	I 206		
	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 GHMRP failed to ensure that all staff had current health certificates on file.			
	The findings include:			
	1. Review of the personnel files conducted on July 11, 2008, revealed the GHMRP failed to provide evidence of current health certificates for one staff.		All of the personnel files will be updated by In the future the mamgement will ensure that all of the personnel files are updated, and that the information is availble upon request.	8-01-08
	2. Review of the personnel files conducted on July 11, 2008, revealed the GHMRP failed to provide evidence of current health certificates for one consultants at the time of the survey. (Pharmacist)		The Pharmacist health certificate is current Refer to attachment # 5	

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I 227	Continued From page 4	I 227		
I 227	3510.5(d) 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 record review, the GHMRP failed to have on file for review current training in First Aid and CPR for employees. The findings include: On July 11, 2008, review of personnel records/training records revealed four staff were without current documentation of First Aid and CPR, or both at the time of the survey.	I 227	The employees will have their CPR, and First Aid by The next CPR and First Aids calsses will be offered on 8-17, and 8-30-08 In the future rhe facility will ensure that all employees have current training in CPR and first Aid.	8-17-08
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 observations, interview and record review, the GHRMP failed to ensure each Resident #2 received continuous active treatment services. The finding includes: On July 10, 2008 at approximately 6:19 PM, direct care staff was observed wiping off the dining table after Resident #2 had completed his dinner meal. At no time did staff encourage Resident #2 to wipe off the table after completing the dinner meal. Interview with the direct care staff on July 10, 2008 revealed that Resident #2	I 422	Individual #2 home management Goal/objective and IPP is in place, and the staff will be inserviced Refer to attachment # 2. In the future the qmrp will ensure the goals are implemented timely to ensure the contineous active treatment.	7-28-08

PRINTED: 07/24/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G217	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2008
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20011		

(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 422	Continued From page 5 had an objective to wipe off the table after dinner with assistance. Review of Resident #2's Individual Program Plan (IPP) dated June 26, 2008 on July 11, 2008 at 9:18 AM revealed a program that stated "the resident will wipe the table after dinner with physical assistance from staff on 80% recorded trails per month for three consecutive months. Review of the staff in service training records on July 11, 2008 revealed that staff had received training on implementing Resident #2's program objectives on June 14, 2008. There was no evidence that training had been effective.	I 422	Individual #2 home management Goal/objective and IPP is in place, and the staff will be inserviced Refer to attachment # 2. In the future tha qmrp will ensure the goal are implemented timely to ensure the contineous active treatment.	7-28-08