

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

PRINTED: 08/28/2012
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 08/17/2012
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 45TH PLACE, SE WASHINGTON, DC 20019	
(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)

W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from August 15, 2012 through August 17, 2012. A sampling of two clients was selected from a population of four men with varying degrees of intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, two family members/guardians, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 331 483.460(c) NURSING SERVICES

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with each client's needs, for one of the two clients in the sample. (Client #2)

The finding includes:

1. The facility's nursing services failed to ensure that Client #2's medication administration record was maintained current, as evidenced below:

Received 9/7/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

It is the policy of this agency that all medications are administered as prescribed by the physician.

In this situation, there was an inaccuracy in the medication dosage (Valproic Acid 250 MG caps).

W 331

The dosage prescribed by the PCP was Valporic Acid 500mg in the morning and 1000mg in the evening.

On 8-15-12, the individual received partial dosage of the Valporic Acid 500mg in the evening instead of 1000mg.

PCP was notified about the discrepancy. PCP instructed to administer next dose as scheduled per order.

Refer to attachment #1a

The TME was inserviced by the facility RN on the medication policy and TME responsibilities.

Refer to attachment #1b

In the future, the facility nursing management will ensure

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

Angele Ejemba

TITLE

Program Director

(X6) DATE

9-7-12

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 331 Continued From page 1

On August 15, 2012, at 8:07 p.m., Staff #1 was observed to punch Valproic Acid 250 mg caps, 2 caps (500 mg) from the bubble pack. Interview with Staff #1 revealed that the client was prescribed the medication for seizure disorder. During this time, it was observed that all medications in the August 2012 bubble pack had been dispensed through August 14, 2012.

On the same evening, at 8:09 p.m., review of the instructions on the medication card for the morning revealed "Valproic Acid 250 mg caps, take 1 capsule in the morning and 2 capsules in the evening by mouth for seizures. (7/30/12)" Further review of the medication card revealed that all medication had been removed from the blister pack through August 15, 2012.

On August 15, 2012, at 8:30 p.m., review of the computerized medication administration record (MAR) for August 2012, revealed the client was to receive Depakote 500 mg in the morning and 1000 mg in the evening. It was also noted that physician's orders dated August 1, 2012 also prescribed Depakote 500 mg in the morning and 1000 mg in the evening.

Discussion with Staff #1 on August 15, 2012, at 8:32 p.m., revealed the designated licensed practical nurse (LPN #1) had mentioned to him that there was a change in Client #2's Depakote at the beginning of August 2012.

A telephone interview was conducted with designated LPN #1 on August 15, 2012, at 8:25 p.m., regarding the discrepancy in Client #2's medication. According to LPN #1, on July 29,

W 331 that all prescriptions are verified for accuracy upon delivery and before the medication administration. The LPM will check the medication regimen once weekly; additionally, all MARs must be maintained current at all times.

It is the policy of this agency that all medications are administered as prescribed by the physician.

In this situation, there was an inaccuracy in the medication dosage (Valproic Acid 250 MG caps).

The dosage prescribed by the PCP was Valporic Acid 500mg in the morning and 1000mg in the evening.

On 8-15-12, the individual received partial dosage of the Valporic Acid 500mg in the evening instead of 1000mg. PCP was notified about the discrepancy. PCP instructed to administer next dose as scheduled per order.

Refer to attachment #1a

The TME was inserviced by the facility RN on the medication policy and TME responsibilities.

Refer to attachment #1b

In the future, the facility nursing management will ensure all prescriptions are verified for accuracy upon delivery, and before medication administration.

The LPN will check the medication regimen once weekly; additionally, all MARs must be maintained current at all times.

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W 331 Continued From page 2
2012, the primary care physician (PCP) gave a telephone order to change the client's Depakote 500 mg a.m. and 1000 mg p.m., to Valproic Acid 250 mg a.m. and 500 mg p.m. LPN #1 revealed that the client had been receiving the Valproic Acid 250 mg a.m. and 500 mg p.m., since it was delivered by the pharmacy on August 1, 2012. The LPN further stated that she would immediately come to the facility to bring the current order and would ensure that the MAR was updated accordingly.

Interview with the facility's registered nurse (RN) and the director of nursing (DON) on August 16, 2012, at 1:32 p.m., revealed that Client #2 began receiving the Valproic Acid 250 mg a.m. and 500 mg p.m. immediately after it was received from the pharmacy on August 1, 2012. Further discussion with the RN revealed, however, that the MAR was not updated to reflect the medication change until August 15, 2012. According to the RN and the DON, it may take a few days after a medication change for the computerized system to update. The DON revealed, however, that a paper MAR should be maintained for medication changes until the system updates to reflect the current physician's orders.

At the time of the survey, there was no evidence the facility's nursing services ensured that the MAR was maintained current for the Valproic Acid administered to Client #2.

2. Cross refer to W368. The facility's nursing staff failed to ensure Client #2 received his prescribed medications as ordered.

W 331 It is the policy of this agency that all medications are administered as prescribed by the physician. In this situation, there was an inaccuracy in the medication dosage (Valproic Acid 250 MG caps). The dosage prescribed by the PCP was Valporic Acid 500mg in the morning and 1000mg in the evening. On 8-15-12, the individual received partial dosage of the Valporic Acid 500mg in the evening instead of 1000mg. PCP was notified about the discrepancy. PCP instructed to administer next dose as scheduled per order. Refer to attachment #1a
The TME was inserviced by the facility RN on the medication policy and TME responsibilities. Refer to attachment #1b
In the future, the facility nursing management will ensure all prescriptions are verified for accuracy upon delivery, and before medication administration.
The LPN will check the medication regimen once weekly; additionally, all MARs must be maintained current at all times.

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W 331 Continued From page 3
On August 15, 2012, beginning at 8:08 p.m., Staff #1 was observed preparing Client #2's medications for administration. Staff #1 revealed that Client #2 was prescribed Topiramate 100 mg by mouth twice daily to manage his seizure disorder. As Staff #1 punched the Topiramate 100 mg tablet from the bubble pack for August 15th, the Topiramate 100 mg tablet scheduled to be administered on August 14, 2012, was observed still in the bubble packet.

Interview with Staff #1 on August 15, 2012, at 8:25 p.m., revealed that he administered Client #2's evening medications on August 14, 2012 and had accidentally not administered the Topiramate 100 mg tablet to the client. Further discussion with Staff #1 revealed that when he discovered the medication was still on the card on August 15th, he informed LPN #1.

On August 15, 2012, at 8:30 p.m., review of the physician's orders dated August 1, 2012, verified that Client #2 was prescribed Topiramate 100 mg tablet by mouth twice daily for seizure disorder.

Interview with LPN #1 on August 15, 2012, at 9:32 p.m. confirmed that Staff #1 informed her of the medication error when she arrived at the facility a few minutes earlier. Further discussion with LPN #1 revealed that Staff #1 would be retrained by the RN before administering medication to the clients again.

The failed facility failed to ensure that Client #2 received his prescribed medications as ordered.

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure

W 331
Staff #1 was inserviced by the House RN on the medication administration on 8-16-12
The incident report was generated by the DSP #1
Refer to attachment #2 a & b
In the future, the facility medical team will ensure that the medications are administered as prescribed.
Staff #1 was inserviced by the House RN on the medication administration on 8-16-12
The incident report was generated by the DSP #1
Refer to attachment #2 a & b
In the future, the facility medical team will ensure that the medications are administered as prescribed.

W 368

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W 368	<p>Continued From page 4</p> <p>that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with physicians' orders for one of two clients in the sample. (Client #2).</p> <p>The findings includes:</p> <p>The facility's nursing staff failed to ensure Client #2 received his prescribed medications as ordered.</p> <p>On August 15, 2012, beginning at 8:08 p.m., Staff #1 was observed preparing Client #2's medications for administration. Staff #1 revealed that Client #2 was prescribed Topiramate 100 mg by mouth twice daily to manage his seizure disorder. As Staff #1 punched the Topiramate 100 mg tablet from the bubble pack for August 15th, the Topiramate 100 mg tablet scheduled to be administered on August 14, 2012, was observed still in the bubble packet.</p> <p>Interview with Staff #1 on August 15, 2012, at 8:25 p.m., revealed that he administered Client #2's evening medications on August 14, 2012 and had accidentally not administered the Topiramate 100 mg tablet to the client. Further discussion with Staff #1 revealed that when he discovered the medication was still on the card on August 15th, he informed designated licensed practical nurse (LPN #1).</p>	W 368	<p>Staff #1 was inserviced by the house RN on the medication administration on 8-16-12 The incident report was generated by the DSP #1 Refer to attachment #2 a & b In the future, the facility medical team will ensure that all medications are administered as prescribed.</p> <p>Staff #1 was inserviced by the house RN on the medication administration on 8-16-12 The incident report was generated by the DSP #1 Refer to attachment #2 a & b In the future, the facility medical team will ensure that all medications are administered as prescribed.</p>

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W 368	Continued From page 5 On August 15, 2012, at 8:30 p.m., review of the physician's orders dated August 1, 2012, verified that Client #2 was prescribed Topiramate 100 mg tablet by mouth twice daily for seizure disorder. Interview with LPN #1 on August 15, 2012, at 9:32 p.m. confirmed that Staff #1 informed her of the medication error when she arrived at the facility a few minutes earlier. Further discussion with LPN #1 revealed that Staff #1 would be retrained by the registered nurse (RN) before administering medication to the clients again. The failed facility failed to ensure that Client #2 received his prescribed medications as ordered.	W 368	Staff #1 was inserviced by the house RN on the medication administration on 8-16-12 The incident report was generated by the DSP #1 Refer to attachment #2 a & b In the future, the facility medical team will ensure all the medications are administered as prescribed.
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices was furnished and maintained in good repair for one of two clients in the sample. (Client #2) The findings include: The facility failed to ensure Client #2's was provided a wheel chair for distance travel, as prescribed.	W 436	

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W 436 Continued From page 6

On August 15, 2012, at 6:00 p.m., Client #2 was observed seated in his recliner talking to Staff #1. Further observation revealed he was wearing a soft helmet and also a gait belt. At 6:15 p.m., Client #2 ambulated with a shuffling gait as he went with Staff #1 to take out the trash.

On August 15, 2012, at 5:21 p.m., interview with Staff #1 revealed he was Client #2's one-on-one staff during the 4:00 p.m. to 12:00 a.m. shift. Interview with the qualified intellectual disabilities professional (QIDP/Staff #8) on August 16, 2012, at 9:09 a.m., revealed the client was prescribed one-on-one supervision 24 hours a day to monitor him for seizures, ensure his safe ambulation, and to manage his maladaptive behaviors. Interview with Staff #3 indicated that the client did not have or require a wheelchair, except on occasion when he was sedated for appointments. Further discussion with the QIDP/Staff 8, and also LPN #1 on August 17, 2012, at 12:49 p.m., indicated that the interdisciplinary team did not recommend a wheelchair for the client.

On August 17, 2012, at 2:52 p.m., record review, however, revealed a current physician's order dated August 1, 2012, for a "wheelchair for distance travel." Further record review revealed the treatment order had been prescribed throughout the survey year.

At the time of the survey, there was no evidence that the facility had addressed Client #2's physician's order for a "wheelchair for distance travel."

W 436:

Individual #2 was re-assessed by the PT during the quarterly review on 8-27-12 and on another note was written on 9-5-12. The use of the Wheelchair for long distance was recommended. 719-A form was completed and signed by the PCP on 9-6-12. Refer to attachment #3 a & b. In the future, the facility will ensure that the the individuals' adaptive equipment are used as prescribed by the consultant.

Individual #2 was re-assessed by the PT during the quarterly review on 8-27-12 and on another note was written on 9-5-12. The use of the Wheelchair for long distance was recommended. 719-A form was completed and signed by the PCP on 9-6-12. Refer to attachment #3 a, b & c. In the future, the facility will ensure that the the individuals' adaptive equipment are used as prescribed by the consultant.

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 15, 2012 through August 17, 2012. A sampling of two residents was selected from a population of four men with varying degrees of intellectual and developmental disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, two family members/guardians, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000		
I 136	<p>3505.6 FIRE SAFETY</p> <p>Each GHMRP shall maintain records of each simulated fire drill.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure fire drills records were monitored and accurately documented.</p> <p>The finding includes:</p> <p>The GHPID failed to ensure accurate documentation and record keeping of all fire drills conducted.</p> <p>Review of fire drill reports on August 16, 2012,</p>	I 136	<p>All staff were inserviced by the QIDP on the fire drills documentation on 8-16-12</p> <p>Refer to attachment #4.</p> <p>In the future, the facility management will ensure that the staff documentation of the drills record are accurate, and monitored; in addition the drills must indicate the dates and time the drills were conducted.</p>	

Health Regulation & Licensing Administration

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

Angela Egan
TITLE

9-7-12
(X6) DATE

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I 206	<p>Continued From page 2</p> <p>inventory/ certificate for one (1) of eleven (11) consultants. (C-8)</p> <p>On August 16, 2012, continued review of the personnel records failed to evidence a physician health inventory/certificate for the speech and language pathologist. (C-8)</p> <p>2. There was no evidence of a physician's health inventory/certificate for four (4) of twelve (12) employee's. (Employee's #3, #6, #8, and #12)</p> <p>On August 17, 2012, continued review of personnel records failed to evidence a physician health inventory/certification for Employee's #3, #6, #8, and #12.</p> <p>On August 17, 2012 at approximately 3:45 p.m., the qualified intellectual disabilities professional (QIDP) stated the the agency would recheck the personnel files to ascertain if the results of Employee's #3, #6, #8, #12 and Consultant C-8's health certifications were in the files. None was found and he placed a call to human resources for an update, but no additional information was received.</p>	I 206	<p>The Speech and Language Pathologist's health certificate was current, however, it was not available upon request during the survey. 8-20-2012</p> <p>Refer to attachment #4</p> <p>In the future, the provider will ensure that all of the consultants' record are available, and provided upon request. Employees #3, 6&12 health certificates are currently on file. Refer to attachment # 5a &b</p> <p>Employee #8 has a medical appointment scheduled for 9-10-12</p> <p>In the future, the agency will ensure that all employees medical record are up to date, and available upon request.</p>
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the group</p>	I 227	

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I 227	Continued From page 3 home for persons with intellectual disabilities (GHPID) failed to ensure one of twelve (12) employees received training on emergency procedures, including first aide (FA), (Employee #12). The finding includes: The GHPID failed to ensure a current first aide training certificate was on file for Employee #12. Interview with the qualified intellectual disabilities professional (QIDP) on August 17, 2012, at 3:45 p.m., verified the GHPID failed to provide evidence that Employee #12 had a current certification in first aide available for review.	I 227	Employee #12's first aid will be on available on 9- In the future, the agency will ensure that all employees medical record are up to date, and available upon request.	