

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 T STREET, SE, WASHINGTON, District of Columbia, 20020		
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E0000	Initial Comments An emergency preparedness survey was conducted at this facility from 08/03/2026 through 08/05/2026. The survey findings determined that the facility was in substantial compliance with the requirements of Emergency Preparedness Requirements for Medicare and Medicaid Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). No deficiencies were cited.	E0000	Please start typing your responses here:		
W0000	INITIAL COMMENTS A recertification survey was conducted at this facility from 08/03/2026 through 08/05/2026. A sample of three clients was selected from a census of five. The survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews, and the record reviews.	W0000			
W0189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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 observations, interview and record reviews, the facility failed to ensure that three of the six Direct Support Professionals (DSPs #4, #5 and #6) were effectively trained on universal precaution including hand hygiene, for the five clients residing in the facility (Clients #1, #2, #3, #4 and #5). Observations on 08/03/2026 beginning at 1:43 PM showed the following:	W0189			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0189	Continued from page 1 - At 2:01 PM, Client #4 propelled herself from the living room to the dining table, and at 2:10 PM, the client was observed seated at the dining table coloring in a book with different crayons. - At 3:30 PM, Clients #2 and #3 both were escorted to the dining table in their custom molded wheelchairs. - At 3:40 PM, Client's #1 who was holding a purple stuffed animal, and Client #5 were transferred from the hospital bed to their wheelchairs and escorted to the living room area. - At 3:50 PM, Client #1 with the staff assistance transferred from her wheelchair to the dining chair by holding the dining table for support. - At 4:00 PM, all the clients were served either chocolate or vanilla pudding for snacks. At no time during this process did DSPs #4, #5 and #6 verbally encouraged or assist the clients with performing hand hygiene prior to eating their snacks. - At 5:50 PM, the DSPs did not verbally instruct and/or assisted all the five clients with performing hand hygiene before or after dinner. During a group interview at 6:45 PM, DSPs #4, #5 and #6 confirmed that the clients were not verbally encouraged and/or assisted the clients with sanitizing/washing their hands prior to and after eating their snacks and dinner meal. When asked, the DSPs confirmed that they have all received training on universal precaution. On 08/05/2026 at 11:55 AM, a review of the facility's in-service training records revealed that on 05/01/2026, all the staff received training on universal precaution.	W0189			
W0192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the Direct Support Professional (DSP) demonstrated	W0192			

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W0192	Continued from page 2 competency in the implementation of each client's mealtime protocol, for two of the three clients in the facility (Clients #1 and #4). a) The review of Client #1's Mealtime Protocol dated 06/29/2026 revealed that the client was prescribed a Mechanical Soft with ground meats and should be supervised due to the potential for rapid food intake. Further review of the protocol revealed that staff were to encourage the client to replace utensils before taking another bite of food and alternate solid and liquid. Additionally, Client #1 was prescribed a Brown Provale cup with lid (10cc) and a note in the record stated "BE SURE LIDS ON CUP DURING MEALS. Observations during dinner on 08/03/2026 at 5:50 PM showed that Client #1 was served a double-portion of ground chicken, Colliflower and brown rice on a high-sided plate. After the meal set-up, Client #1 was began eating independently at a semi-rapid pace and continued to put food in her mouth spoonful after spoonful while DSP #4 who was positioned directly beside the client failed to intervene to slow down and take a sip of beverage. At 5:55 PM, the Licensed Practical Nurse (LPN) walked out of the office to the dining table and said to the DSP, "give her [Client #1] something to drink because her mouth is full and she continues to put food inside her mouth". DSP #4 then instructed the client to put down the spoon and drink some water. Client #1 picked up a two-handle cup without a top and began to drink the water. It should be noted that there was a brown lid on the dining table near Client #1, and at no time did DSP #4 place the brown lid on the client's cup. DSP #4 during an interview on 08/05/2026 at 3:11 PM regarding Client #1's mealtime protocol stated that according to the protocol, Client #1 was to be supervised at all times due to eating fast and should be prompted to take a sip of beverage between every bite using her two-handle cup with the brown lid. When asked why he did not verbally encourage Client #1 to place the spoon down after each bite and drink from the cup during dinner on 08/03/2026, DSP #4 stated that, "I was feeding Client #2. I should have been more attention to Client #1 as she has a history of eating at a fast pace. Also, I should have made sure that the client's brown lid was placed on her cup to decrease in the flow of water." DSP	W0192			

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W0192	Continued from page 3 #4 confirmed that he had been trained on Client #1's Mealtime Protocol. b) The review of Client #4's Mealtime Protocol dated 01/13/2026 indicated that the client was prescribed a Mechanical Soft diet due to the client eating quickly. Further review of the protocol revealed that staff were to provide verbal cues to slow down as needed when eating. Dinner observations on 08/03/2026 at 5:50 PM showed that Client #4 was served ground chicken, Colliflower and brown rice on a high/low plate. After the meal set-up, the client began eating independently at a quick pace. DSP #5 who was positioned in front of Client #4 provided no verbal clues for the client slow down and to take a sip of beverage between bites. At 5:55 PM, the Licensed Practical Nurse (LPN) came to the dining table and verbally prompted Client #4 to put the spoon down and drink some water. The client placed the spoon down, retrieved a cup and began to drink water. On 08/05/2026 at 2:37 PM, a review of the facility's in-service training records revealed that on 05/08/2026 and 06/01/2026 all the staff had received training on the clients Mealtime Protocols. During an interview on 08/05/2026 at 3:08 PM, DSP #5 confirmed receiving training on Client #4's Mealtime Protocol.	W0192			
W0247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is NOT MET as evidenced by: Based on observations, interview and record reviews, the facility failed to provide each client with a choice of snacks during snack time, for the five clients residing in the facility (Clients #1, #2, #3, #4 and #5). Observations on 08/03/2026 at 4:00 PM showed that all the clients were served either chocolate or vanilla pudding for snacks. There were no other choices of snacks offered to the clients. An inspection of the kitchen at 4:18 PM revealed that there was Oreo yogurt, applesauce, cookies, crackers and donuts available for the clients to choose from.	W0247			

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W0247	Continued from page 4 Direct Support Professional (DSP) #4 on 08/03/2026 at 4:49 PM, during an interview regarding the clients receiving only chocolate and/or vanilla pudding during snack time, had no explanation on why the clients were not offered other available snack in the kitchen.	W0247	Please start typing your responses here:		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 reviews, the facility failed to ensure that each client's active treatment program (i.e. handwashing) was implemented as recommended, for one of the three clients in the sample (Client #1). A review of Client #1's Individual Program Plan (IPP) dated 09/25/2025 revealed the following objective: "[client name] will wash her hands before and after meals with 25% physical assistance from staff for 3 consecutive months by 9/25/2026." The IPP listed the following action steps: - Staff will assist [client name] to the sink. - Once at the sink staff will assist [client name] with putting soap on, lathering her hands, turning on the water, washing hands together, rinsing her hands, turning off water, then drying hands. Outcome: With staff assistance [client name] will improve her infection control by washing hands often. Observations on 08/03/2026 at 3:40 PM showed Client #1 who was holding a purple stuffed animal transferred with staff assistance from a hospital bed to the wheelchair and escorted to the living room area. At 3:50 PM, the client was escorted to the dining table and assisted staff with transferring	W0249			

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W0249	Continued from page 5 from the wheelchair to the dining chair by holding the dining table for support during snack time. During dinner at 5:50 PM, Client #1 was served a double-portion of ground chicken, Colliflower and brown rice on a high-sided plate. At no time was Client #1 verbally encouraged to wash her hands during, before or after snack and dinner. Further observations at 6:44 PM showed Client #1 with food particles on her hands and sticky fingers prior to receiving her evening medications. DSP #4 on 08/05/2026 at 3:11 PM, DSP #4 during an interview regarding Client #1's IPP objectives confirmed that the client had an objective to wash her hands before and after meals. The DSP acknowledged that he did not verbally instruct the client to wash her hands before or after snack and dinner time. On 08/05/2026 at 3:18 PM, a review of the facility's staff in-service training records showed that on 06/01/2026, all staff received training on Client #1 IPPs goals and objectives.	W0249			