

STATE OF MARYLAND
FORM APPROVED

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0006 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/23/2009 |
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| NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010 | | |
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| 1 000 | INITIAL COMMENTS A recertification survey was conducted from 2/19/2009 to 2/23/2009. A random sampling of four residents was selected from a population of eight individuals with varying degrees of disabilities. The result of the survey was based on observation, staff interviews, as well as a review of the resident and administrative records, including a review of the unusual incident reports. | 1 000 | | |
| 1 042 | 3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement a resident's nutritional plan for one of four sampled residents. [Resident #2] The finding includes: 1. Observation during dinner on 2/19/2009 at 4:50pm revealed Resident #2 received his meal in whole portions. He received a meal of Rotini (twisted) pasta and chicken in tomato sauce, tossed salad, yellow rice, biscuits and cooked squash. He began eating his meal with his hands before staff attempted to cut his chicken into smaller chunks with a spoon. The resulting product appeared to be of a "bite sized" consistency (smaller than whole pieces of varying sizes). Record review on 2/20/2009 at 4:33pm revealed Resident #2's Nutritional Assessment dated 1/5/2009 recommended a "regular diet, | 1 042 | | |

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Justine A. Reese
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director
TITLE

(X6) DATE
4/28/09

STATE FORM

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If continuation sheet 1 of 1

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| 1042 | Continued From page 1 chopped, lactose free, hi fiber" diet. His current physician's order sheets (POS) also prescribed a "regular, lactose free, chopped" diet. Interview with the QMRP, HM and LPN on 2/20/2009 at 5:30pm revealed there was no consensus amongst them with regards to what constituted a "chopped" texture. The facility failed to ensure that Resident #2 received his meals in the required "chopped" texture. [See W460 & W474] 2. Record review on 2/20/2009 at 4:35pm revealed Resident #2's Nutritional Assessment dated 1/5/2009 recommended to "add wheat germ to food to increase fiber content". Wheat germ was not observed being added to Resident #2's meal on the evening of 2/19/2009. Interview with the QMRP and HM on 2/20/2009 at 5:54pm verified the wheat germ was not added to the meal as prescribed by the Nutritionist. In addition, the HM questioned the staff who was present during dinner the night before and found that they were not aware wheat germ was a required addition for Resident #2's meals. | 1042 | 1. Cross reference W460 2. Cross reference W460 | 4/10/09 4/10/09 |
| 1077 | 3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident's seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to provide clothes racks and shelves for one of the eight residents residing in the facility. [Resident #1] The finding includes: | 1077 | | |

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| 1077 | Continued From page 2 On 2/20/2009 at approximately 1:30pm, Resident #1's clothes were observed intermingled with his roommates in a small closet. Both of his roommates were afforded additional storage space, but he was not. Interview with the HM at approximately 1:35pm revealed he was not sure why Resident #1's clothing was not separated in the small closet or why he was not afforded any private storage space. There was no evidence Resident #1 was provided adequate storage for his personal clothing within the confines of his bedroom. | 1077 | An additional storage cabinet was purchased for Resident #1. | 2/23/09 |
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| 1080 | 3503.8 BEDROOMS AND BATHROOMS One (1) bathroom consisting of a toilet, lavatory and a bathing facility that is appropriate for the needs of the residents shall be provided for the use of each six (6) persons including staff, except that non-live-in staff shall not be counted when calculating persons using bathing facilities. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the use and function of at least two bathrooms for eight of eight residents residing in the facility. [Residents #1, #2, #3, #4, #5, #6, #7, #8] The finding includes: During the environmental inspection on 2/20/2009 at 3:15pm, the shower nozzle in the bathroom on the third floor was broken. Interview with the HM on 2/20/2009 at 4:32pm revealed, the only bathroom that was being used for showering was the one on the second floor. At the time of survey, there were eight residents and four staff | 1080 | All bathrooms within the facility will be used for bathing. The shower nozzle in the bathroom on the 3rd floor will be replaced. QMRP/ HM will monitor that all bathrooms are utilized for | |
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| 1080 | Continued From page 3 on duty during the evening hours. When asked about the bathroom in the basement, the HM revealed they do not use the one in the basement for showering. According to the HM, all eight Residents were using the bathroom on the second floor for showering and/or bathing purposes. | 1080 | showering. | 4/30/09 |
| 1082 | 3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and staff interview and record review, the GHMRP failed to ensure that cup dispensers were in good repair for eight of eight residents residing in the facility. The finding includes: During the environmental inspection on 2/20/2009 at 2:46pm, the cup dispenser in the basement bathroom appeared damaged. The section which houses the cups was missing and just the base of the unit remained on the bathroom wall. Interview with the house manager at 2:47pm revealed they would have the broken item repaired or replaced the following day. | 1082 | The cup dispenser will be replaced. | 4/30/09 |
| 1090 | 3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of: | 1090 | | |

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| I 169 | <p>Continued From page 5</p> <p>(g) Resident life, which covers clothing, management of funds, resident rights, discipline, behavior management, services, parental and guardian involvement, visitation, staff treatment of residents, and resident work.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure provisions to properly manage the Resident ' s clothing as required by this section.</p> <p>The finding includes:</p> <p>Review of the facility ' s Policy and procedure manual on 2/20/2009 at 3:30pm revealed there was no provision for the upkeep or management of clothing. Interview with the facility ' s HM on 2/20/2009 at 3:35pm revealed, the company ' s policy on clothing did not address the upkeep of clothing. [Reference Citation 3504.17]</p> | I 169 | <p>Policy will be revised to include provisions for the upkeep and management of residents clothing.</p> | 5/6/09 |
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| I 183 | <p>3508.4 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) implemented an effective system of coordinating resident services and treatment for two of four sampled residents. [Residents #1 & #2]</p> | I 183 | | |
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| I 183 | <p>Continued From page 6</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Observation on 2/19/2009 and 2/20/2009 revealed Resident #1 wore a gait belt throughout the evening. Record review revealed Resident #1's Psychology assessment dated 6/30/2008 recommended that the Occupational Therapist and the Physical Therapist should assess the gait belt and establish recommendations for safety precautions. There was no evidence on file at the time of survey to substantiate that the necessary coordination of services was ensured to implement this recommendation. [See Federal Deficiency Report Citation W189] 2. The QMRP failed to ensure the implementation of a clear written intervention to manage a resident's physical aggression. [See Federal Deficiency Report Citation W240] 3. The QMRP failed to ensure the consents for the use of psychotropic medications. [See Federal Deficiency Report Citation W263] 4. The QMRP failed to ensure the skill level and training of the facility's staff. [See Federal Deficiency Report Citations W189 & W192] 5. The QMRP failed to ensure the implementation of a continuous active treatment program. [See Federal Deficiency Report Citation W196] 6. The QMRP failed to ensure the implementation of a programmatic plan to address the need to have a resident sedated prior to dental appointments. [See Federal Deficiency Report Citation W312] 7. The QMRP failed to ensure the proper | I 183 | <ol style="list-style-type: none"> 1. Cross reference W196 (2) 2. Cross reference W196 (4) 3. Cross reference W263 4. Cross reference W196 (2) 5. Cross reference W196 (4) 6. Cross reference W312 7. Cross reference W460 | <p>02/23/2009</p> <p>4/6/09</p> <p>4/6/09</p> <p>4/6/09</p> <p>4/6/09</p> <p>4/6/09</p> <p>4/30/09</p> <p>4/10/09</p> |

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| I 183 | Continued From page 7 implementation of modified diets and food textures for residents. [See Federal Deficiency Report Citations W460 & W474] | I 183 | | |
| I 222 | <p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee utilized a residents' adaptive equipment effectively and failed to ensure correct meal textures as required by their individual Program Plans for two of four sampled residents. [Resident #1 and Resident #2]</p> <p>The findings include:</p> <p>Observation on 2/19/2009 revealed Resident #1 was equipped with a helmet and gait belt which he wore throughout the evening. The securing strap on Resident #1's gait belt hung approximately twelve inches from his waist and dangled against his upper hip as he walked around the facility. Staff was observed sitting in the armchair near the dining room and utilized the strap to hold Resident #1 back from entering the dining room while the table was being set for dinner. While staff was holding the strap, Resident #1 was observed to trip over the staff's feet on one occasion and on another fall over the arm of the armchair and into the staff's lap. The loss of balance occurred while staff was attempting to manage Resident #1's movement while holding the strap. The staff was also observed using the waistline of Resident #1's pants to hold him back as well.</p> | I 222 | Cross reference W196 (1) | 4/6/09 |

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| I 222 | Continued From page 8 Further record review on 2/20/2009 at 1:31pm revealed Resident #1's Annual Nursing Assessment dated 06/13/2008 recommended ... "Close observation at all times to prevent injury associated with unsteady gait and posture" ... "Protective helmet to be worn during waking hours" ... and "assist with ambulation". In support for his ambulating needs, Resident #1 's 2/2009 physician order sheets reflected he was ordered to be provided a Gait Belt on 02/19/07. Interview with the facility 's HM and QMRP on 2/23/2009 at 3:44pm revealed there was no training on file to direct staff on the proper use of Resident #1 's gait belt. The facility failed to ensure staff was effectively trained on the use of Resident #1 's gait belt. [Reference W196] | I 222 | | |
| I 432 | 3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the proper instructional care and oversight to ensure a Resident maintained proper hygiene for one of four sampled residents. [Resident #2] The finding includes: Observation throughout the evening on 2/19/2009 revealed Resident #2 's sweat top was soiled and in poor sanitary condition. Resident #2 was | I 432 | Cross reference W455 | 4/10/09 |

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| 1500 | <p>Continued From page 10</p> <p>protective helmet and the use of psychotropic medications for one of four sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>Observation between the dates of 2/19/2009 and 2/23/2009 revealed Client #1 was wearing a helmet. Review of the 2/2009 Physician Order Sheets (POS) on 2/23/2009 at 1:05pm revealed Client #1 has a history of seizures and was prescribed a "protective helmet" on 06/26/2002.</p> <p>Observation of the evening medication administration on 2/19/2009 revealed, Client #1 was administered 5mg of Haloperidol. Record review on 2/23/2009 at 1:04pm revealed the Haloperidol was prescribed to manage his behavior.</p> <p>Further record review revealed Client #1's Psychological assessment dated 6/8/2008 detailed, "due to cognitive deficits consistent with profound mental retardation, [Client #1] does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, ongoing medical care, client placement and financial matters. He does not have the capacity to choose the person he desires to make those decisions for him, and could not execute a durable power of attorney."</p> <p>Interview with HM and further record review on 2/23/2009 at 2:28pm verified there was no evidence on file to reflect Client #1 was assigned a legal guardian. The facility failed to ensure that the use of the helmet and the use of the psychotropic medication were enacted under the written consent of a legally sanctioned advocate.</p> | 1500 | | |

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| 1500 | <p>Continued From page 11</p> <p>[See Federal Deficiency Report Citation W124]</p> <p>2. Based on record review, the facility failed to ensure that programs which incorporate restrictive techniques and the use of medications to control behaviors were conducted only with the written informed consent of the client or legal guardian for one of the four clients included in the sample. (Client #1)</p> <p>The findings include:</p> <p>Observation of the evening medication administration on 2/19/2009 revealed, Client #1 was administered 5mg of Haloperidol. Record review on 2/23/2009 at 1:04pm revealed the Haloperidol was prescribed to manage his behavior.</p> <p>Further record review revealed Client #1's Psychological assessment dated 6/8/2008 detailed, "due to cognitive deficits consistent with profound mental retardation, [Client #1] does not evidence the capacity to make decisions on his own behalf in treatment, habitation, ongoing medical care, cliential placement and financial matters. He does not have the capacity to choose the person he desires to make those decisions for him, and could not execute a durable power of attorney."</p> <p>Interview with HM and further record review on 2/23/2009 at 2:28pm revealed there was no evidence that an advocate or legal guardian was made aware of Client #1 was provided a helmet or that psychotropic medications were being used to manage his behavior. There was also no evidence on file to substantiate that the Human Rights Committee (HRC) had reviewed and/or addressed the fact there was no legally</p> | 1500 | | |

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| 1500 | <p>Continued From page 12</p> <p>sanctioned advocate to consent for the treatment. The facility failed to ensure its HRC reviewed and monitored the use of the helmet and the use of the psychotropic medications. [See Federal Deficiency Report Citation W263]</p> <p>3. Based on record review and staff interview, the facility failed to ensure the implementation of a programmatic plan to reduce the need for sedations for one of four sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Review of Client #2's dental records on 2/20/2009 at 5:00pm revealed Client #2 was administered 2mg of Ativan as a sedation measure on 1/8/2009 to secure his dental appointment. Further record review revealed Client #2's 1/8/2009 sedation with the Ativan was also recorded on his 1/2009 MAR and the LPN indicated that his sedation was to ensure that he could complete his dental appointment. Interview with the QMRP, HM and the facility's RN on 2/20/2009 at 5:17pm revealed the there was no evidence on file at the time of survey to substantiate that an Individual Program Plan was created was in place to manage or work to eliminate the need for sedations.</p> <p>The facility failed to ensure sedations were being used as part of an IPP to reduce or eventually eliminate Client #2's inappropriate behavior as required by this section. [See Federal Deficiency Report Citation W312]</p> | 1500 | | |