

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER IDENTIFICATION NUMBER: 09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2009
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DEFICIENCIES PRECEDED BY FULL IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS A recertification survey was conducted from December 16, 2009 through December 18, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of four female clients and one male client with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.		W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that staff working with clients at their day programs (1) implemented communication programs, (2) provided assistance during meals at the appropriate level of support, and (3) ensured continuous wheelchair safety, for one of the three clients in the sample. (Client #2) The findings include: On December 16, 2009, Client #2 was observed at her day program from 11:25 a.m. until 12:15 p.m. 1. At 11:44 a.m., direct support staff could not locate Client #2's communication device.		W 120		
			W120	1. Staff received additional training from the QMRP on 12-18-09 to insure they understood the importance of taking Client #2's communication device to the day program consistently. The QMRP discussed the issue with the day program and agreed to use a formal documentation process (a standard sign off form) to verify receipt of the communication device daily as well as daily pick up by the residential staff. The facility manager and QMRP will routinely check the forms to insure that staff is consistently providing the device and bringing it home daily...2-9-10.	

Received 2/16/10
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Evelle Moore</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/4/10</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's current 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 120	<p>Continued From page 1</p> <p>According to both the direct support staff and the day program case manager who were present, the home had not been secured. The device in the client's backpack as required. They presented program data sheets from November and December 2009, on which staff had documented that the communication device had been available on November 2nd and 3rd and on December 2nd and 4th but was unavailable on all other days during those periods. The case manager then presented an Intra-Agency Communication note, dated November 23, 2009, in which the day program staff alerted the home to the problem.</p> <p>2. At 11:57 a.m., a direct support staff person presented a lunch plate that consisted of pureed chicken, peas and other foods. The staff placed an angled spoon into the client's left hand and immediately began providing her with hand-over-hand assistance as she ate her first mouthfuls. The staff continued providing hand-over-hand assistance for the remainder of the meal. Earlier that day, however, Client #2 had been observed feeding herself breakfast, while using the adaptive spoon.</p> <p>3. During the meal (at 12:08 p.m.), it was observed that the client's wheelchair safety harness was not properly secured. The harness strap was draped loosely across her elbow region rather than fastened properly down her shoulder and chest.</p> <p>While still at the day program, at 12:38 p.m., review of Client #2's "Annual Summary, dated June 2009, revealed that the client was "dependent upon staff to perform all activities of daily living except self-feeding. <Client's name></p>	W 120	<p>2. The QMRP discussed the feeding concern (Client #2) with the day program and provided the day program with a new copy of the prescribed feeding protocol. Client #2 can eat independently using the adaptive spoon prescribed for her and should be allowed to do so daily at all meals. The QMRP and facility manager will insure that meal observations are done during routine, monthly visits to the program to insure ongoing compliance by the day program staff...2-5-10.</p> <p>3. The QMRP will meet with day program staff for Client #2 to insure they understand how to properly use the harness and will offer to train staff on its use...2-18-10.</p> <p>Additionally, the QMRP will monitor compliance during her monthly visits to the program as will the facility manager during periodic visits...3-5-10.</p>	
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STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2009
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W 120	<p>Continued From page 2</p> <p>requires staff supervision during meals... My ultimate vision: to increase my independence..."</p> <p>4. The qualified mental retardation professional (QMRP) was interviewed the next day (December 17, 2009) at approximately 9:20 a.m. She stated that Client #2 was generally able to feed herself with the angled spoon. Staff would only provide hand-over-hand assistance if necessary. The QMRP further indicated that she had visited Client #2's day program; however, she could not recall whether that had included a mealtime observation.</p> <p>5. On December 17, 2009, at 4:10 p.m., the QMRP was interviewed further, along with the house manager (HM) and the RN. All three concurred that the client's safety harness should be secured across her chest and shoulders at all times while she is seated in her wheelchair. They all agreed that staff should allow Client #2 to feed herself using the adaptive spoon.</p> <p>6. On December 18, 2009 at approximately 9:20 a.m., the QMRP and HM were asked about Client #2's communication device. Neither was aware that the client had been without the device at her day program on the day before. The HM presented the device and then demonstrated how it should be used. She and the QMRP indicated that the overnight shift staff were expected to place the communication device in Client #2's backpack and the day shift staff were to inspect her bag before leaving for day program to ensure that the device was in their possession. The HM further stated that she spoke with staff after receiving the November 23, 2009 note from the day program. Further interview, however, revealed that neither she nor the QMRP had been monitoring since</p>	W 120	<p>4. See response for #2 above.</p> <p>5. See response for #3 above.</p> <p>6. See response for #1 above.</p>	

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W 120	Continued From page 3 then to ensure that the client had her device with her and/or that her communication program was being implemented at the day program.	W 120		
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, staff interview, and record review, the facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #1) The finding includes: During the morning medication pass observed on December 16, 2009, Client #1 was administered Risperdal 1 mg at approximately 7:30 a.m. During the entrance conference a short while later, at approximately 9:30 a.m., the qualified mental retardation professional (QMRP) and house manager (HM) indicated that Client #1's Risperdal was incorporated in his behavior support plan (BSP). They further indicated that his sister was his designated surrogate health care decision-maker. On December 17, 2009, at 11:14 a.m., review of Client #1's Individual Support Plan dated July 29,	W 124	W124 The sister of Client #1 will have the accurate Risperdal regimen reviewed with her and have the risks/benefits discussion once again in order to obtain proper, informed consent for the regimen. This review will occur by...2-14-10. In the future, the RN and QMRP separately will audit the forms to insure they are completed accurately and fully...2-14-10.	

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W 124	<p>Continued From page 4</p> <p>2009, revealed that the client was not competent to make health care or financial decisions and "has a sister who signs medical issues as needed. Client #1's record failed to show evidence that the sister had been fully informed of the client's mental health status and the risks and benefits associated with the use of Risperdal. She had not signed the attendance sheet for his ISP meeting and there was no written consent form for the use of Risperdal observed in his record.</p> <p>On December 18, 2009, at 1:10 p.m., review of Client #1's POs revealed that he had previously been taking Risperdal 1 mg twice daily, as well as Klonopin. His record indicated that he was hospitalized between June 11-24, 2008, during which time they discontinued both medications. The POs reflected that Client #1 remained off of both medications for approximately 8 months after being readmitted to the facility on June 24, 2008.</p> <p>Subsequent review of Client #1's Psychotropic Medication Reviews revealed that he had been "stable, redirectable" and otherwise "doing well off medications" until February 2009, at which time he had a spike in incidents of physical aggression. On February 4, 2009, the psychiatrist prescribed a resumption of Risperdal.</p> <p>At 1:41 p.m., the QMRP was asked when the sister had been informed of Client #1's behavioral changes and the psychiatrist's recommendation that he resume taking Risperdal. She acknowledged that the facility contacted the sister on the day before (December 17, 2009) and discussed the issues. She then presented a consent form that the sister had signed</p>	W 124		

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W 124 W 130	<p>Continued From page 5</p> <p>December 17, 2009 for 1 n g Risperdal daily. [Note: The client was actually receiving 1 mg twice daily, two times the dosage represented on the consent form.] The QIP acknowledged that the facility had not informed the sister timely. 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, the facility failed to ensure that the clients' right to privacy during medication administration was protected, for two of the five clients residing in the facility. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. The morning medication pass was observed on December 16, 2009, beginning at 7:12 a.m. Staff brought one client at a time into the living room to receive their medications. The medication nurse explained that this process was used to ensure privacy. Beginning at 7:45 a.m., Client #3 repeatedly refused her medications. She was taken from the living room at 7:51 a.m. At 8:04 a.m., two nurses brought her back into the living room and offered her verbal and physical prompts to take her medications. During the 6 minutes that followed, other staff came through the living room, sometimes with other clients. There were yet other clients eating breakfast at the dining table, which was situated approximately six feet away, and within view of Client #3.</p>	W 124 W 130	<p>W130</p> <p>The RN has retrained one of the two medication nurses on the privacy issue, giving particular attention to privacy considerations when passing medications...2-1-10. The second medication passing nurse is out of the country and is scheduled to return the second week of February. She will be trained on the subject by...2-15-10. Additionally, MTS' protocol for appropriate medication passing is stored in the front of the medication administration record at each location. Nurses will be retrained on its mandates and reminded to review the guide prior to initiating the medication pass...2-10-10.</p>	
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W 130	Continued From page 6 2. Another nurse administered the evening medications. At 5:30 p.m., the nurse brought Client #1's medications to the dining room table. He first administered crushed medications in apple sauce, and then he administered eye drops. There were four staff and several clients present in the dining room at that time.		W 130	The RN will observe medication passes periodically to insure routine compliance with the prescribed guidelines. The QMRP and facility manager separately will observe a medication pass at least once weekly to insure the same and will report to the RN any issues observed. The RN will in turn follow up with the relevant nurse... 2-10-10.	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: Interview with the qualified mental retardation professional (QMRP), house manager (HM) and review of the facility's financial records on December 18, 2009, beginning at 10:32 a.m., revealed that the facility assisted Clients #1, #2 and #3 with maintaining their finances. Continued interview and record review revealed that the clients received Supplemental Security Income (SSI) in the amount of \$700 per month. a. Client #1's bank statements were reviewed from December 2008 through November 2009 and revealed the following withdrawal:		W 140		

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W 140	Continued From page 7 - June 24, 2009, in the amount of \$34.00. There were no receipts. b. Client #2's bank statements were reviewed from December 2008 through November 2009 and revealed the following withdrawals: - June 24, 2009, in the amount of \$34.00. There were no receipts. - February 23, 2009, in the amount of \$800.00. There were no receipts. c. Client #3's bank statements were reviewed from December 2008 through November 2009 and revealed the following withdrawals: - June 24, 2009, in the amount of \$34.00. There were no receipts; and - March 10, 2009, in the amount of \$775.00. There were receipts totaling \$334.74. At the time of the survey, the facility failed to ensure a complete accounting of the clients personal funds by providing evidence that justified the aforementioned withdrawal.	W 140	W140 The \$800 dollar withdrawal from Client #2's account was for some major purchases that did not occur. The money was returned to the account (See: attached deposit slip copy)...2-1-10. For Client #3's withdrawal of \$775.00, \$334.74 was the amount spent. The Client Accounts manager was instructed to deposit the remainder in the client account but failed to do so. The Director of Finance will insure that the balance is returned to the client account by...2-5-10. The Director of Finance now meets with the Client Accounts manager on a weekly basis to review the status of accounts to insure that all accounts are properly reconciled at all times. The Director of Finance also conducts periodic audits to insure consistency in follow up...2-10-10. The \$34.00 dollar withdrawals were for tickets for an event that ultimately was not attended by the individuals that originally planned to do so. These \$34.00 balances should have been returned to the Client accounts and will be by...2-5-10.	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by. Based on interview and record review, the facility	W 148		

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W 148	<p>Continued From page 8</p> <p>failed to ensure clients' family members were informed of injuries of unknown origin, for one of the three clients in the same. (Client #1)</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on December 16, 2009, beginning at 8:50 a.m., revealed an incident involving Client #1 dated August 31, 2009. According to the report, staff discovered skin off his scrotum, measuring two centimeters in diameter. The medication nurse was notified and she applied Vitamin A & D ointment.</p> <p>An interview was conducted with the qualified mental retardation professional (QMRP) on December 16, 2009, at approximately 11:30 a.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents should be reported to the administrator, family members and governmental agencies. Further review of the incident report, however, revealed no documented evidence that Client #1's family member (sister) had been notified of this injury.</p>	<p>Client #1 did not have an injury of unknown origin but rather a skin breakdown in the scrotum area. This was assessed and determined by both the RN and PCP and confirmed via follow up with dermatology (See: Attached consultation report). A therapeutic topical cream was prescribed, obtained and administered as per the prescribed regimen and the issue is now resolved as indicated elsewhere in the survey by the monitors...2-1-10.</p> <p>The facility manager reports that she did indeed notify Client #1's sister of the skin breakdown but acknowledged that she failed to document the contact. The QMRP will re-train the facility manager to insure future compliance and will review incident reports prior to submission to insure all fields are correctly completed and to insure that proper notifications occur...2-10-10.</p>	W 148		
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure the mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with established procedures.</p> <p>This STANDARD is not met. Based on interview and review of incident reports</p>	<p>as evidenced by: review of incident reports</p>	W 153		

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W 153	<p>Continued From page 9</p> <p>and client records, the facility failed to ensure that all injuries of unknown origin were reported immediately to the State Agency [DOH/HRLA], for one of the five clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>On December 18, 2009, at approximately 10:45 a.m., review of Client #1's nurse progress notes revealed that on November 13, 2009 at 4:35 p.m., a nurse documented that a direct support staff had "called this nurse to report that <client's name> had a small scratch on his forehead. Requested him to clean with soap and water and ... report to next nurse that comes in facility. Called the day program to report..." Review of incident reports in the facility at the beginning of this survey, on December 15, 2009, had not shown that this injury had been reported.</p> <p>At approximately 11:05 a.m., interview with the house manager (HM) revealed that an incident report had been prepared. She telephoned the facility's incident management coordinator (IMC) and then left the room to find the incident report. At 11:30 a.m., the HM presented the original incident report dated November 13, 2009 which she said she found on the qualified mental retardation professional's desk. At 12:13 p.m., the HM presented documentation that had been faxed to the facility moments earlier by the IMC. Review of the documents revealed that the incident had not been reported to the IMC timely. The IMC, therefore, notified the DOH/HRLA on November 23, 2009, 10 days after the scratch of unknown origin was discovered on Client #1's forehead.</p>		W 153	<p>W153</p> <p>MTS increased its IMC personnel to include a staff IMC (QMRP) in addition to the consulting RN used as the primary IMC. The staff IMC is charged with insuring that all incident reports are submitted to all necessary parties in a timely manner. The IMC acknowledged that this particular incident was not submitted in a timely manner. The Executive Director will meet with the IMC on a monthly basis to insure that all incident reports and investigations are submitted in a timely manner. The IMC will prepare reports that outline the submission timelines for all incidents and the status of outstanding investigations...2-20-10.</p>	
W 154	483.420(d)(3) STAFF TRAINMENT OF		W 154		

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W 154	<p>Continued From page 10 CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin, for three of the five clients residing in the facility. (Clients #1, #3 and #4)</p> <p>The findings include:</p> <p>On December 16, 2009 at approximately 9:55 a.m., the qualified mental retardation professional (QMRP) and house manager (HM) stated that the facility's policy required that all injuries of unknown origin must be investigated. They agreed to make available for review all incident reports and their corresponding investigations.</p> <p>1. Cross-refer to W153. On December 18, 2009, at approximately 10:45 a.m., review of Client #1's nurse progress notes revealed that when the client returned from day program on November 13, 2009, at 4:35 p.m., staff discovered a scratch on his forehead. Documentation related to the incident indicated that the cause of the injury was not known. A nurse documented that she left a telephone message for the nurse at Client #1's day program that afternoon. The same nurse documented on November 16, 2009, (3 days after the injury) that she had spoken with the day program nurse who "was not aware of the scratch mark but will talk with staff." No additional information was provided. At approximately 10:53 a.m., interview with the nurse revealed that she had not had further discussion with the day</p>	W 154	<p>W154</p> <p>See responses for W153 above. Additionally, the QMRP will insure in the future that an approved investigator is assigned to investigate any incidents that require it and will track follow up to completion...2-20-10</p> <p>The QMRP will assist the investigation process in each case (The QMRP is not an approved investigator)...2-20-10.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/CLIA IDENTIFICATION NUMBER: 09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2009
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-18 JAY STREET, NE WASHINGTON, DC 20019
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W 154	<p>Continued From page 11</p> <p>program regarding the November 13, 2009 injury. At approximately 11:32 a.m., review of the corresponding incident report and interview with the HM revealed that to date, the cause of the injury had not been investigated. No additional information was presented before the survey ended at 6:00 p.m. later that day.</p> <p>2. On December 18, 2009 at 1:00 p.m., review of minutes taken at an August 31, 2009 Human Rights Committee meeting revealed that they had discussed a "scratch on Client #1's scrotum." The corresponding incident report did not indicate that the cause of this injury had been investigated. At 1:15 p.m. interview with the QMRP confirmed that the cause of this injury had not been investigated.</p> <p>3. Review of the facility's incident reports on December 16, 2009, beginning at 8:50 a.m., revealed an incident report dated July 7, 2009. The report indicated that Client #3 fell down the stairs and was sent to the emergency room. Further review revealed an investigative report. In an interview with the QMRP on December 16, 2009, at approximately 11:30 a.m., she acknowledged there was no investigation to the aforementioned incident. There was no evidence that the incident had been investigated.</p> <p>Further interview and record review indicated that a Fall Precaution Protocol had been developed and implemented August 2009. According to the Fall Precaution Protocol, direct care staff should be stationed upstairs, while Client #3 sleeps at night. Since the implementation of the Fall Precaution Protocol, there have been no falls reported for Client #3.</p>	<p>ember 13, 2009 injury. review of the report and interview with the HM revealed that to date, the cause of the injury had not been investigated. No additional information was presented before the survey ended at 6:00 p.m. later that day.</p> <p>at 1:00 p.m., review of minutes taken at an August 31, 2009 Human Rights Committee meeting revealed that they had discussed a "scratch on Client #1's scrotum." The corresponding incident report did not indicate that the cause of this injury had been investigated. At 1:15 p.m. interview with the QMRP confirmed that the cause of this injury had not been investigated.</p> <p>incident reports on December 16, 2009, beginning at 8:50 a.m., revealed an incident report dated July 7, 2009. The report indicated that Client #3 fell down the stairs and was sent to the emergency room. Further review revealed an investigative report. In an interview with the QMRP on December 16, 2009, at approximately 11:30 a.m., she acknowledged there was no investigation to the aforementioned incident. There was no evidence that the incident had been investigated.</p> <p>record review indicated that a Fall Precaution Protocol had been developed and implemented August 2009. According to the Fall Precaution Protocol, direct care staff should be stationed upstairs, while Client #3 sleeps at night. Since the implementation of the Fall Precaution Protocol, there have been no falls reported for Client #3.</p>	W 154	<p>2. As mentioned earlier, the scrotum area of Client #1 suffered a skin breakdown not a "scratch" and was successfully treated with prescribed topical cream. The cause of the "scratch" was known not unknown as confirmed by dermatology follow up...2-1-10.</p> <p>3. There was no formal investigation done based on the fall but as mentioned by the surveyors, appropriate steps were taken to minimize the likelihood of future fall. The fall precaution protocol developed is being implemented consistently and is working effectively to date. MTS will insure via the IMC personnel and via routine meetings/monitoring by the Executive Director that investigations are completed even when the potential injury is of known origin as was the case here...2-1-10.</p> <p>It should be noted that Client #3 was not injured in the fall as demonstrated by the ER report and internet examinations...2-1-10.</p>	

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09G183

(X2) MULTIPLE CONSTRUCTION
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B. WING _____

(X3) DATE SURVEY COMPLETED

12/18/2009

NAME OF PROVIDER OR SUPPLIER

MULTI-THERAPEUTIC SERVICES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
4414-18 JAY STREET, NE
WASHINGTON, DC 20019

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W 194 Continued From page 13

At 6:22 a.m., S1 removed the lid from a breakfast plate and informed Client #3 that she was being served cereal, eggs and cornbread (all pureed). S1 tried placing a spoon with a built-up handle into Client #3's hand; however, the client was still wearing the mitts and did not take the spoon. At 6:23 a.m., the staff began feeding the client. At 6:31 a.m., the staff observed that Client #3 was refusing to eat more so she covered the plate and wheeled the client out of the room "to check her for wetness." They returned to the table at 6:39 a.m. and S1 presented the breakfast plate again. S1 gave her verbal encouragement to eat and brought the adaptive spoon to the client's right hand. The client, however, had her right hand in her mouth (still wearing her mitts) and refused to take the spoon. The client continued mouthing her hand mitt. At 6:42 a.m., the staff presented a spoonful of food but the client kept the mitt in her mouth, rejecting the food. At 6:43 a.m., the staff presented a spoonful of food to the left corner of Client #3's mouth, while the client continued mouthing her right hand mitt. The client again refused to eat. At 6:44 a.m., the staff covered the plate and wheeled the client out to the living room.

Later that day (December 16, 2009), at 3:40 p.m., interview with the registered nurse (RN) revealed that Client #3 should be given her Boost nutritional supplement after she has eaten her breakfast. She further stated that it would not be appropriate to give Boost to her before her meal because the Boost "fills you up."

On December 18, 2009, at 8:05 a.m., review of Client #3's mealtime procedures dated July 30, 2009, revealed the following procedures:

W 194

The RN will insure that staff is clear that the Boost is to be given after the meal and not before and will as well address the proper use of the mitts at mealtimes...2-14-10.
The QMRP and facility manager will observe at least one meal weekly between them for each shift (i.e. a breakfast, a dinner, a weekend lunch and a fourth) to insure that all staff follows the prescribed protocols...2-20-10.

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W 194	<p>Continued From page 14</p> <p>a. staff should allow [the client] to eat independently with verbal prompts;</p> <p>b. if [the client] does not eat after 3-5 minutes of food being served, staff should provide verbal prompts;</p> <p>c. if [the client] does not eat after 5-10 minutes, staff should provide hand over hand assistance;</p> <p>d. if [the client] declines, staff should feed her;</p> <p>e. if [the client] attempts to hand mouth, staff should use gentle physical and verbal prompts to redirect her back to eating</p> <p>f. allow [the client] extended time to complete her meal (30-45 minutes); and</p> <p>g. if [the client] declines to finish her entire meal provide fluids and supplement intake.</p> <p>On December 18, 2009, beginning at approximately 11:00 a.m., review of staff in-service training records revealed that the staff who were observed assisting Client #3 at breakfast had received training on the client's mealtime protocol on October 2, 2009. Observations on December 18, 2009, however, indicated that the training had not been effective.</p>	W 194		
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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</p>	W 249		

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W 249	<p>Continued From page 15</p> <p>and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff implemented clients' Behavior Support Plans (BSPs), for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On December 16, 2009, 7:35 a.m., Client #3 was observed with gloves on her hands and tape wrapped around each wrist. At 7:52 a.m., the client was observed removing the gloves and sticking her hands into her mouth. At 8:00 a.m., the direct support staff was observed taking the client to the bathroom, washing her hands and replacing the gloves onto her hands. At 8:02 a.m., the client removed the gloves and began sticking her hands in her mouth again. At 8:04 a.m., the direct care staff adjusted the glove on the client's right hand, only. The left hand remained without a glove. At 8:15 a.m., the client was observed sticking both hands into her mouth. The direct care staff was heard asking the client to "remove your hands from your mouth."</p> <p>During the entrance conference on December 16, 2009, beginning at 9:25 a.m., the qualified mental retardation professional (QM) and house manager (HM) revealed that Client #3 had a Behavior Support Plan (BSP) to address hand mouthing. Further interview indicated the client used hand mittens to maintain healthy hand skin.</p>	W 249	<p>W249</p> <p>The QMRP will conduct a training session with staff on the proper implementation of Client #3's BSP by...2-5-10. Psychology will provide further training by...2-20-10. Additionally, the QMRP and facility manager will conduct routine weekly observations to insure that staff follows the BSP when the hand-to-mouth behavior presents itself...2-15-10. The QMRP and facility manager will provide on-the-spot training when they observe improper implementation of the BSP strategies and will document the training for the record...2-15-10.</p>	
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W 249	<p>Continued From page 16</p> <p>Review of the Client #3's clinical record on December 18, 2009, at 10:52 am., revealed a BSP dated June 13, 2009. The BSP had a targeted behavior of self-stimulatory hand mouthing. The BSP revealed the following procedures to address the behavior:</p> <ul style="list-style-type: none"> - provide verbal redirection - if [the client] begins to hand mouth, redirect her to a sensory "scheduled activity" with one to one supervision; - provide materials or gentle body movement; - engage [the client] for 10-15 minutes; - gently assist [the client] by taking her hands out of the mouth; - offer [the client] items to hold, place headphones on her; - if [the client] continues to hand mouth for 30 minutes, place the gloves on her hands and direct her to an activity with physical movement; - remove the gloves after 15 minutes and offer activities again; and, - alternate periods of gloves on if [the client] is persistent with gloves off and interventions. <p>On December 16, 2009, facility staff failed to implement Client #3's BSP as instructed.</p>	W 249		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p>	W 263		

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W 263	<p>Continued From page 17</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consent was obtained from the appropriate healthcare decision-maker, for one or more of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Cross-refer to W124. The facility failed to obtain written consent from Client #1's sister prior to beginning the use of Risperdal 1 mg twice daily, effective February 24, 2009. Minutes taken at meetings of the facility's Human Rights Committee (HRC) for the period January 2009 - November 2009 were reviewed on December 18, 2009, beginning at 12:52 p.m. The minutes documented HRC discussion regarding the Risperdal on February 24, 2009, and again on July 31, 2009. Neither minutes reflected consideration given to whether the sister had provided written consent.</p>	W 263	<p>W263</p> <p>The sister of Client #1 will have the accurate Risperdal regimen reviewed with her and have the risks/benefits discussion once again in order to obtain proper, informed consent for the regimen. This review will occur by...2-14-10.</p> <p>In the future, the RN and QMRP separately will audit the forms to insure they are completed accurately and fully...2-14-10.</p>	
W 331	<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, staff interview and record review, the facility failed to ensure nursing</p>	W 331		

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W 331	<p>Continued From page 18</p> <p>services as needed by changes in clients' health care status, for three of the five clients residing in the facility. (Clients #1, #3 and #4)</p> <p>The findings include:</p> <p>1. The facility nurses failed to update Client #3's Health Management Care Plan (HMCP), as follows:</p> <p>On December 18, 2009, at approximately 10:30 a.m., review of the Client #3's December 2009 physician orders revealed an order for a cardiology evaluation for kithargy. Further record review revealed a cardiology consult report dated October 27, 2009. The cardiology consult recommended the following: check Dilantin levels, CBC, CMP laboratory studies and return in four months.</p> <p>Review of Client #3's HMCP dated June 2009, on December 18, 2009, at 10:30 a.m., revealed that it did not address cardiology. When interviewed on December 18, 2009, at 11:00 a.m., the registered nurse (RN) acknowledged that the HMCP had not been updated to reflect cardiology services.</p> <p>2. Review of Client #1's medical records on December 17, 2009, beginning at 2:55 p.m., revealed that facility nurses failed to revise his HMCP to reflect the onset of "skin breakdown," a decubitus stage 1 wound, as follows:</p> <p>Review of the facility's incident reports on December 16, 2009, beginning at 8:50 a.m., revealed an incident report dated August 31, 2009. The report indicated that staff discovered "skin off his scrotum measuring 2 cm in</p>	W 331	<p>W331</p> <ol style="list-style-type: none"> The HMCP has been updated to include the concern for Client #3...2-1-10. The HMCP has been updated to address the concern for Client #1...2-1-10. <p>The RN will insure that any new, acute concern that develops is added to the HMCP. The Director of Nursing will audit compliance via her routine medical record reviews and will provide feedback and direction to the RN if issues are found...2-15-10. The RN is also required to report on the status of HMCP updates during monthly meetings with the DON...2-1-10.</p>	
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 diameter." They notified the nurse and applied Vit. A & D ointment, in accordance with Client #1's POs. When interviewed, the RN stated that the skin had since healed.

 On December 17, 2009, at 2:55 p.m., review of Client #1's HMCP, dated July 18, 2009, revealed no skin-related care plan instructions. At 3:11 p.m., review of the RN's monthly nursing reviews revealed that "skin breakdown" had been observed a month after the August 31, 2009 incident (on September 26, 2009). The client's POs reflected that the PCP ordered Zinc Oxide 20% cream, effective September 29, 2009; "apply to affected area topically to buttocks and scrotum areas after each diaper change for decubitus stage 1 until healed then I RN." Continued review of the HMCP revealed that it had not been updated or revised since July 18, 2009, to address skin integrity and preventive skin care.

 [Note: Review of the RN monthly summaries revealed that as of October 12, 2009, the wound had "resolved." The November 12, 2009 monthly summary included "Skin breakdown healed. Zinc Oxide used PRN."]

W 331

3. See responses for W368 below.

W 368 483.460(k)(1) DRUG ADMINISTRATION

 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

 This STANDARD is not met as evidenced by:

W 368

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W 368	<p>Continued From page 20</p> <p>Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders (POs), for one of the five clients residing in the facility. (Client #4)</p> <p>The findings include:</p> <p>The morning medication administration pass was observed on December 18, 2009, beginning at 7:11 a.m. The two following errors were observed:</p> <p>1. At 7:56 a.m., the medication nurse attempted to administer Client #4's Artificial Tears. The client, however, squinted her eyes shut, flailed her hands wildly and made sharp vocalizations. While the client protested, the nurse administered one drop of Artificial Tears near each eye. Less than 1/2 of the drop of fluid actually made it into the client's eye; the rest was wiped away with a paper towel. At approximately 5:20 p.m., review of Client #4's December 2009 POs revealed that she was prescribed two drops Artificial Tears into each eye, twice daily for dry eyes.</p> <p>2. The facility failed to ensure timely administration of newly-prescribed medications, as follows:</p> <p>On December 16, 2009, at approximately 5:21 p.m., review of Client #4's POs revealed that she had an order dated December 13, 2009, to start receiving Ferrous Sulfate 325 mg by mouth twice daily to treat anemia. The client had not received Ferrous Sulfate during the medication pass observed that morning. The RN was present at the time. She stated that she had obtained the medication that day. When interviewed, the</p>	W 368	<p>W368</p> <ol style="list-style-type: none"> 1. A protocol has been developed outlining strategies that maximize the likelihood of cooperation from Client #4 in administering the needed eye drops. Nurses will be trained to use the protocol by...2-5-10. 2. MTS has developed a nursing office in the field that will be charged with insuring that all medications are ordered, received, checked, stored and entered on the MARs in a timely manner. The Administrative LPNs assigned this task will insure that all medications are ordered and properly stored in a timely manner and that the MARs are set up for appropriate sign off...2-15-10. 	

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W 368	Continued From page 21 evening medication nurse sometimes took 2 or 3 days to fill new prescriptions. The nurse said the Ferrous Sulfate was available on-site and he planned to administer it to Client #4 that evening.	Indicated that it was before the pharmacy. He said the Ferrous Sulfate was available on-site and he planned to administer it that evening.	W 368	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for three of the five clients residing in the facility. (Clients #1, #3 and #4) The findings include: 1. The morning medication administration pass was observed on December 16, 2009 beginning at 7:11 a.m. The following errors were observed: a. Client #1 did not receive eye drops in accordance with his physician's orders (POs), as follows: At 7:39 a.m., the medication nurse approached	At 2:05 p.m., review of procedures revealed "All new medications will be ordered and administered within 48 hours of the time prescribed by the physician." Approximately 72 hours passed between the time Client #4's Ferrous Sulfate and the time that it was first administered. ADMINISTRATION must assure that all drugs, including those that are self-administered, are administered without error. not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for three of the five clients residing in the facility. The findings include: 1. The morning medication administration pass was observed on December 16, 2009 beginning at 7:11 a.m. The following errors were observed: a. Client #1 did not receive eye drops in accordance with his physician's orders (POs), as follows: At 7:39 a.m., the medication nurse approached	W 369	Additionally, the RN will call the medication nurse responsible for administering the first dose of a new medication to insure that the nurse is aware of the new medication...2-5-10. The RN will also audit implementation at minimum weekly to insure timely follow up and may request similar audit support from the QMRP...2-5-10. W369 a. A protocol has been developed outlining strategies that maximize the likelihood of cooperation from Client #4 in administering the needed eye drops. Nurses will be trained to use the protocol by...2-5-10.

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
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W 369 Continued From page 22

Client #1 with a bottle of Artificial Tears. She stated that he was prescribed the eye drops, 1 drop into each eye, twice daily for dry eyes. The client tilted his head forward and was resistant to the nurse's attempts to administer the drops. While his head was still leaning forward, she squeezed the dropper and 2 drops fell onto the outer aspect of his lower right eye lid. None of the medication made it into his right eye. While the liquid rolled down his right cheek, she dabbed it with a paper towel. She used the same procedure with his left eye. The client remained resistive and only a tiny fraction of the drop of Artificial Tears actually made it onto the lower left eye lid. Throughout the process, the nurse did not offer the client any verbal instructions or encouragement to cooperate. Later that afternoon, at approximately 4:30 p.m., review of Client #1's December 2009 POs confirmed that he was prescribed one drop Artificial Tears into each eye twice daily for dry eyes.

On December 17, 2009 at 4:01 p.m., interview with the RN revealed that she used the 3 following steps to encourage Client #1's cooperation with eye drop administration: (1) tell him how the eye drops will benefit him, (2) ask him to please tilt his head back, and (3) apply a gentle touch to his left eyebrow. She indicated that applying those three strategies concurrently would elicit his cooperation. The morning nurse had not, however, utilized effective techniques to ensure proper administration of the eye drops.

b. Similarly, Client #4 did not receive eye drops in accordance with her POs as follows:

Cross-refer to W368.1. The medication nurse administered less than one drop of Artificial Tears

W 369

b. Same as above for Client #1.

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W 369	<p>Continued From page 23</p> <p>into Client #4's right and left eyes. At approximately 5:20 p.m., review of her December 2009 POs revealed that she was prescribed two drops Artificial Tears into each eye, twice daily for dry eyes.</p> <p>c. The morning medication pass routinely was performed more than one hour past the designated administration time and the facility's nursing department failed to resolve this timing error, as follows:</p> <p>On December 16, 2009, the morning medication nurse arrived at the facility at 7:02 a.m. The medication pass took place between 7:12 a.m. - 8:25 a.m. Review of the five clients' Medication Administration Records (MARs) later that day, beginning at 4:17 p.m., revealed that the designated administration time was 8 a.m.</p> <p>The next morning, review of the visitor's log revealed that between November 15, 2009 - December 15, 2009, the weekday morning medication nurse consistently signed-in between 6:55 a.m. - 7:11 a.m. [Note: There were no signed arrival times documented for any Saturday or Sunday mornings during that same 1-month period.]</p> <p>On December 17, 2009, at 3:49 p.m., the RN and the qualified mental retardation professional (QMRP) were asked about the designated administration time. They indicated that they were both previously aware that the weekday morning nurse was administering medications later than the one-hour afforded by standard nursing practices. The current morning nurse reportedly began arriving late sometime in October or early November 2009. The RN stated</p>	<p>At review of her December 2009 POs revealed that she was prescribed two drops Artificial Tears into each eye, twice daily for dry eyes.</p> <p>pass routinely was performed more than one hour past the designated administration time and the facility's nursing department failed to resolve this timing error, as follows:</p> <p>at 7:02 a.m. The medication pass took place between 7:12 a.m. - 8:25 a.m. Review of the five clients' Medication Administration Records (MARs) later that day, beginning at 4:17 p.m., revealed that the designated administration time was 8 a.m.</p> <p>of the visitor's log revealed that between November 15, 2009 - December 15, 2009, the weekday morning medication nurse consistently signed-in between 6:55 a.m. - 7:11 a.m. [Note: There were no signed arrival times documented for any Saturday or Sunday mornings during that same 1-month period.]</p> <p>the RN and the qualified mental retardation professional (QMRP) were asked about the designated administration time. They indicated that they were both previously aware that the weekday morning nurse was administering medications later than the one-hour afforded by standard nursing practices. The current morning nurse reportedly began arriving late sometime in October or early November 2009. The RN stated</p>	W 369	<p>c. The RN has discussed the issue with the DON and PCP. All agree that the regimens can be changed to 7am and 7pm. This will create a new two hour window of 6am to 8am which is better for the individuals supported and more feasible for the medication nurse while also not compromising the effectiveness of the regimen for any person supported. This change will be made by...2-5-10.</p>	
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W 369	<p>Continued From page 24 that she had considered changing the designated time from 6:00 a.m. up to 7:00 a.m. However, the Director of Nursing (DON) instructed them to maintain the current time because Client #2 was taking Reglan, which had to be administered 30 minutes prior to her breakfast.</p> <p>2. Review of Client #1's medical records on December 17, 2009, beginning at 2:55 p.m., revealed that direct support staff continued administering a PRN ointment three times daily, even though it was no longer indicated, as follows:</p> <p>Review of the facility's incident reports on December 16, 2009, beginning at 8:50 a.m., revealed an incident report dated August 31, 2009. The report indicated that staff discovered "skin off his scrotum measuring 2 cm in diameter." They notified the nurse and applied Vit. A & D ointment, in accordance with Client #1's POs. When interviewed, the RN stated that the skin had since healed.</p> <p>On December 17, 2009, at 3:11 p.m., review of the RN's monthly nursing views revealed that "skin breakdown" had been observed a month after the August 31, 2009 incident (on September 26, 2009). The client's PO reflected that the PCP ordered Zinc Oxide 20% cream, effective September 29, 2009; "applied topically to buttocks and scrotum areas after each diaper change for decubitus stage 1 until healed then PRN." Continued review of the RN's monthly summaries revealed that as of October 12, 2009, the wound had "resolved." The November 12, 2009 monthly summary included "Skin breakdown healed. Zinc Oxide used PRN."</p>	<p>changing the designated time from 6:00 a.m. up to 7:00 a.m. However, the Director of Nursing (DON) instructed them to maintain the current time because Client #2 was taking Reglan, which had to be administered 30 minutes prior to her breakfast.</p> <p>ical records on December 17, 2009, beginning at 2:55 p.m., staff continued administering a PRN ointment three times daily, even though it was no longer indicated, as follows:</p> <p>ent reports on December 16, 2009, beginning at 8:50 a.m., dated August 31, 2009. The report indicated that staff discovered "skin off his scrotum measuring 2 cm in diameter." They notified the nurse and applied Vit. A & D ointment, in accordance with Client #1's POs. When interviewed, the RN stated that the skin had since healed.</p> <p>3:11 p.m., review of the RN's monthly nursing views revealed that "skin breakdown" had been observed a month after the August 31, 2009 incident (on September 26, 2009). The client's PO reflected that the PCP ordered Zinc Oxide 20% cream, effective September 29, 2009; "applied topically to buttocks and scrotum areas after each diaper change for decubitus stage 1 until healed then PRN." Continued review of the RN's monthly summaries revealed that as of October 12, 2009, the wound had "resolved." The November 12, 2009 monthly summary included "Skin breakdown healed. Zinc Oxide used PRN."</p>	W 369	<p>2 The RN and QMRP will track implementation of as needed topical creams and ointments aimed at addressing specific, acute concerns to insure that such creams are stopped in timely manner once the problem is effectively addressed. The QMRP as directed by the RN or the RN will write a "STOP" or "Discontinue" note on the data sheet and/or instruction sheet so that staff or nurses are clearly instructed about the medication...2-10-10.</p> <p>Additionally, the RN will insure that medication that should be removed from the storage area, are removed in a timely manner. The RN will conduct medication cabinet audits to effectively monitor this consideration...2-10-10.</p>	
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W 369	<p>Continued From page 25</p> <p>On December 18, 2009, beginning at 10:27 a.m., review of the MARs on which the direct support staff had been documenting the application of topical medications, including Client #1's Zinc Oxide, revealed that they had continued applying the Zinc Oxide to his scrotum and rectal area after each diaper change through the months of November and December 2009, even though the wound had healed.</p> <p>3. The facility failed to ensure that Client #3 received his Debrox ear drops as prescribed.</p> <p>Review of Client #3's POs dated June 24, 2009, on December 16, 2009, at approximately 2:30 p.m., revealed an order to administer Debrox two drops, twice a day for ten days.</p> <p>Review of Client #3's MARs dated June 2009, on December 18, 2009, at approximately 10:00 a.m., revealed Debrox two drops twice a day had been administered for 13 doses.</p> <p>During a face to face interview with RN on December 18, 2009, at approximately 11:00 a.m., she acknowledged that Debrox drops was administered for "only" 13 doses.</p>		W 369	<p>3 The RN did follow up interviews with medication nursing to ascertain why the drops were stopped before the ten day period and no plausible reason was given. The nurses involved received feedback in the form of a verbal warning from the RN about the importance of insuring that all medications and treatments are implemented consistently as prescribed...2-2-10.</p> <p>In the future, the RN, QMRP and facility manager working as a team will monitor such regimens to insure that they are implemented consistently as prescribed. The QMRP and facility manager will remind the nurse if she/he appears to be omitting the medication during a med pass and will inform the RN about the necessity to provide the prompt to the relevant nurse. The RN and/or DON will follow up with appropriate action up to and including replacing the offending nurse for repeated errors...2-5-10.</p>	
W 382	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's nurse failed to ensure all biological and drugs were locked except while</p>		W 382		

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W 382	<p>Continued From page 26</p> <p>being prepared for administration, for four of the five clients residing in the facility (Clients #1, #2, #4 and #5)</p> <p>The finding includes:</p> <p>Observation on December 16, 2009, at 4:50 p.m., revealed a tray of medications on a cabinet counter top. On the tray was a bottle of Client #1 and #4's artificial tears, Client #2's Nasonex spray, and Client #5's Fluticasone Propionate 0.1% Ointment. Interview with a licensed practical nurse (LPN) on December 16, 2009, at 4:59 p.m., revealed that the tray of medications sat on the counter top, "all the time." Further interview with the registered nurse confirmed the LPN's statement.</p>	W 382	<p>W382</p> <p>The medications mentioned are stored in the locked cabinet and all nurses have been trained to insure that this is the proper storage area for all medications...2-1-10. The QMRP and facility manager will monitor storage routinely and report to the RN any failure to secure medication in the locked cabinet...2-5-10. The RN will also audit such concerns during her home visits...2-5-10.</p>	
W 390	<p>483.460(m)(2)(i) DRUG LABELING</p> <p>The facility must remove from use outdated drugs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility's nurse failed to remove from use, outdated controlled substance medications, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On December 16, 2009, at 4:50 p.m., during an inspection of the medication cabinet, a bottle holding two Lorazepam 2 mg pills was observed in a plastic bag. The label on the bottle indicated an expiration date of June 19, 2009. The Licensed Practical Nurse on duty at that time examined the label and confirmed that the medication had expired.</p>	W 390	<p>W390</p> <p>The expired medication has been properly disposed of...2-1-10. The medication cabinet will be audited at minimum twice monthly by the RN or the administrative support LPNs to insure that expired medications are disposed of in a timely manner...2-5-10. Quarterly reviews with the pharmacist are also completed to insure expired medications are properly disposed of and the facility manager audits topical creams applied with (direct support professional) staff support bimonthly...2-5-10.</p>	

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W 390	Continued From page 27	W 390		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish a system that ensured provision of, and the timely maintenance of clients' adaptive and assistive devices, for two of the three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to obtain a safety, chest harness for Client #1's wheelchair in accordance with physician's orders, as follows:</p> <p>On December 17, 2009, at approximately 2:12 p.m., review of Client #1's physical therapy records revealed a note dated June 12, 2009, in which the PT indicated that the client needed a "new chest harness" for his wheelchair. The client, however, had not been observed wearing a chest harness during the first day of this survey. On December 17, 2009, at 4:48 p.m., the HM, QMRP and the RN stated that Client #1's</p>	W 436	<p>W436</p> <p>1. A new harness has been ordered for Client #1 but the individual's Gait Belt will be used in the interim...2-5-10.</p>	

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W 436	<p>Continued From page 28</p> <p>wheelchair did not require a harness. At 4:27 p.m., the QMRP acknowledged the June 12, 2009 PT note then stated that she thought this issue had "been resolved" since that time. The QMRP could not, however, locate a PT note or other form of documentation to substantiate that the harness was no longer needed.</p> <p>On December 18, 2009, at 1:07 p.m., review of Client #1's physician's orders (POs) revealed that on February 12, 2009, the primary care physician (PCP) wrote an order to "Add harness to wheelchair to prevent him from falling out." Further review of the POs, followed by additional interviews with the QMRP and RN revealed no evidence that the PCP had discontinued the February 12, 2009 order.</p> <p>2. The facility failed to implement a system that ensured effective monitoring of Client #1's safety helmet, as follows:</p> <p>On December 16, 2009, at 9:06 a.m., staff placed a safety helmet on Client #1's head, as he prepared to leave for day program. The helmet had a large (approximately 2-inch) crack visible on the front, right area. When asked, neither of the two direct support staff persons there with him had previously noticed the crack.</p> <p>On December 17, 2009, beginning at approximately 3:33 p.m., the house manager (HM), qualified mental retardation professional (QMRP) and the RN were interviewed together. All three stated that they were previously unaware that Client #1's helmet was cracked. Staff had not informed them of the monitoring observations on the previous day. They said that the strap on his helmet had "just come loose about two weeks"</p>	W 436	<p>2. A new helmet has been obtained for Client #1...2-1-10</p>	

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W 436	Continued From page 29 prior to this survey, and the HM reportedly had ordered a new strap. At 6:02 p.m., the RN indicated that she had inspected the helmet and confirmed the crack on the front. She also identified another crack that was on the back of the helmet. On December 18, 2009, at approximately 10:00 a.m., the QMRP presented a checklist from Client #1's program book. The checklist was a daily accounting of the client's adaptive equipment. Review of the checklist revealed that direct support staff had documented that the helmet was in good repair on every day thus far in December, including the past three mornings. The QMRP and the HM acknowledged that the staff had not documented the damaged helmet (strap or cracks) on the checklist. Neither of them knew how long ago the cracks first appeared on the helmet and they acknowledged that they had not verified the accuracy of the data on the checklist prior to this survey. 3. The facility failed to maintain Client #3's wheelchair in good repair, as follows: On December 16, 2009, at approximately 7:40 a.m., Client #3 was observed in her wheelchair. The left side of the armrest was observed torn and worn down, exposing the metal framework. Interview with the QMRP on December 16, 2009, at approximately 3:30 p.m., revealed that she had no knowledge of the worn armrest. Review of the client's adaptive equipment checklist on December 18, 2009, at 10:00 a.m., revealed that staff had been documenting that the wheelchair was in good repair.	W 436		
W 455	483.470(i)(1) INFECTION CONTROL	W 455	3. A new wheelchair had been requested for Client #3 via the 719A process prior to the survey but has not yet been approved. MTS is awaiting response from Medicaid/Medicare and will follow up as indicated once feedback is obtained. The QMRP and RN will follow up until the new wheelchair is obtained and will document progress in their monthly notes...2-20-10.	

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W 455	<p>Continued From page 30</p> <p>There must be an active program for the prevention, control, and investigation of infectious and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement infectious control procedures to prevent communicable infectious diseases.</p> <p>The finding includes:</p> <p>On December 16, 2009, at 9:25 a.m., a direct care staff was observed putting dishwasher liquid into a basin, washing Client #2's breakfast dishes and then placing them in a dish rack on the counter top. The plates and cups were stacked on top of each other, preventing air flow. Inquiry was made to the house manager (HM) on December 18, 2009, at 2:30 p.m.. She stated that the dishwasher was operating properly. Further discussion revealed that when staff hand washed the dishes, they were expected to use bleach to properly sanitize the dishes.</p> <p>Review of the facility's in-service training record on December 18, 2009, at approximately 12:30 p.m., revealed no evidence of infection control training.</p>	W 455	<p>W455</p> <p>The staff member in question was re-trained on hand dishwashing... 12-18-10. All staff will be re-trained by... 2-15-10. Staff will be trained to use the automatic dishwasher routinely and to do hand dishwashing only if there is a problem with the automatic dishwasher... 2-15-10.</p> <p>The RN will conduct infection control training for staff by... 12-15-10. New staff candidates receive the training during their initial orientation... 2-1-10.</p>	

Health Regulation Administration

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1 000	INITIAL COMMENTS A licensure survey was conducted from December 16, 2009 through December 18, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of four female residents and one male resident with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	1 000		
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for five of five residents included residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: An environmental inspection conducted on December 18, 2009, beginning at 3:00 p.m. revealed the following:	1 090	3504.1 1. Mattress removed...12-30-09. 2. Light bulbs and cover replaced...12-30-09. 3. Light bulb replaced...12-22-09. The facility manager will audit the physical environment using the standard MTS forms on a bimonthly basis and report findings to the Assistant to the Executive Director for timely follow up...2-15-10.	

Health Regulation Administration	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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1090	Continued From page 1 1. There was an old mattress out in the backyard; 2. There were missing light bulbs and a light cover in Client #3's bathroom; and 3. There were missing light bulbs on the stairwell close to Client 3's bedroom.	1090		
1188	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff, and... This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the GHMRP failed to ensure that the organizational chart showed the numbers of supportive and direct care staff. The findings include: 1. On December 17, 2009, at 9:52 a.m., the house manager presented an organizational chart (dated December 2006) that did not show the number of direct support staff employed by the GHMRP. 2. Discussions on the first day of survey had indicated that the GHMRP had nurses with the title of medication nurse. The December 2006 organizational chart, however, did not reflect that position. Interview with the RN on December 17, 2009, at 3:33 p.m., confirmed that the facility employed three medication nurses. 3. Further review of the organizational chart	1188	3508.5(c) See: The attached organizational charts...2-1-10 MTS will insure that the home's policy manual has the most updated charts...2-5-10.	

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I 186	Continued From page 2 indicated a position of nursing coordinator. However, interview with the RN on December 17, 2009, at 3:33 p.m., revealed that position had been discontinued. Instead, management had changed the role and responsibilities of the supervisory RN. In addition, the agency had changed the title of the former Nurse Manager to that of Director of Nursing. On December 17, 2009, at approximately 3:35 p.m., the QMRP acknowledged that the organizational chart had not been updated to reflect the changes made since December 2008.	I 186		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for three of the three residents in the sample. (Residents #1, #2 and #3) The findings include: Interview with the qualified mental retardation professional (QMRP), house manager (HM) and review of the facility's financial records on December 18, 2009, beginning at 10:32 a.m., revealed that the facility assisted Residents #1, #2 and #3 with maintaining their finances. Continued interview and record review revealed that the residents received Supplemental Security Income (SSI) in the amount of \$70.00 per month. a. Resident #1's bank statements were reviewed	I 189		

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1189	<p>Continued From page 3</p> <p>from December 2008 through November 2008 and revealed the following withdrawal:</p> <p>- June 24, 2009, in the amount of \$34.00. There were no receipts.</p> <p>b. Resident #2's bank statements were reviewed from December 2008 through November 2009 and revealed the following withdrawals:</p> <p>- June 24, 2009, in the amount of \$34.00. There were no receipts.</p> <p>- February 23, 2009, in the amount of \$800.00. There were no receipts.</p> <p>c. Resident #3's bank statements were reviewed from December 2008 through November 2009 and revealed the following withdrawals:</p> <p>- June 24, 2009, in the amount of \$34.00. There were no receipts; and</p> <p>- March 10, 2009, in the amount of \$775.00. There were receipts totaling \$334.74.</p> <p>At the time of the survey, the facility failed to ensure a complete accounting of the residents personal funds by providing evidence that justified the aforementioned withdrawal.</p>	1189	<p>3508.7</p> <p>The \$800 dollar withdrawal from Client #2's account was for some major purchases that did not occur. The money was returned to the account (See: attached deposit slip copy)...2-1-10.</p> <p>For Client #3's withdrawal of \$775.00, \$334.74 was the amount spent. The Client Accounts manager was instructed to deposit the remainder in the client account but failed to do so. The Director of Finance will insure that the balance is returned to the client account by...2-5-10.</p> <p>The Director of Finance now meets with the Client Accounts manager on a weekly basis to review the status of accounts to insure that all accounts are properly reconciled at all times. The Director of Finance also conducts periodic audits to insure consistency in follow up...2-10-10.</p> <p>The \$34.00 dollar withdrawals were for tickets for an event that ultimately was not attended by the individuals that originally planned to do so. These \$34.00 balances should have been returned to the Client accounts and will be by...2-5-10.</p>	
1206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p>	1206		

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I 206	<p>Continued From page 4</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel and consultant records, the GHRP failed to ensure that all staff obtained annual health certificates/inventories.</p> <p>The findings include:</p> <p>On December 16, 2009, at approximately 10:15 a.m., the house manager (HM) and qualified mental retardation professional agreed to make available for review the personnel records for all employees and consultants including evidence of annual health certificates/inventories. Review of the personnel records on December 17, 2009, beginning at 4:57 p.m., revealed the following:</p> <ol style="list-style-type: none"> 1. There was no health certificate/inventory made available for review for 1 of the 12 direct support staff (S4), and 3 of the 7 nurses (N4, N5 and N6). 2. The health certificates/inventories on file for 2 of the remaining 4 nurses had expired, as follows: (N1 expired on 1/12/08 and N3 on 5/1/09). 3. There was no health certificate/inventory made available for review for 1 of the 10 professional health consultants (C5). 4. The health certificates/inventories on file for all remaining professional health consultants had expired (C1, C2, C3, C4, C6, C7, C8, C9 and C10). <p>At 6:36 p.m., the HM said she would ask their corporate office for additional documentation. No</p>	I 206	<p>3509.6</p> <p>See: Attached, current health certificates...2-1-10 All others have been given until 2-15-10 to submit current health certificates...2-15-10. MTS will audit compliance quarterly and will provide proactive feedback to staff and consultants that need to provide updated information...2-15-10 Failure to follow up will result in appropriate actions by MTS...2-15-10.</p>	

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I 206	Continued From page 5 additional information was provided before the survey ended the following day.		I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, recreation, total communication, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing residents' mealtime protocol, for one of the three residents in the sample. (Resident #3) The findings include: On December 16, 2009, at approximately 6:15 a.m., a direct support staff person (S1) offered Resident #3 a container of Boost nutritional supplement at the breakfast table. The client, who was wearing green mitts on both hands, drank it readily. At approximately 6:18 a.m., another staff person (S2) observed that Resident #3 had removed her right mitt and was mouthing on her exposed thumb. Staff S2 wiped the resident's hand with a washcloth and then wheeled her out of the dining room. They returned to the dining room table at 6:21 a.m. and the resident's right hand mitt was secured with white tape at the wrist. The resident was mouthing her right thumb (in the mitt) throughout this process. At 6:22 a.m., S1 removed the lid from a breakfast plate and informed Resident #3	I 229	3510.5(f) The facility manager has conducted training with six staff members on the mealtime protocol for Client #3 and the RN will follow up with training for the entire group...2-14-10. The RN will insure that staff is clear that the Boost is to be given after the meal and not before and will as well address the proper use of the mitts at mealtimes...2-14-10. The QMRP and facility manager will observe at least one meal weekly between them for each shift (i.e. a breakfast, a dinner, a weekend lunch and a fourth) to insure that all staff follows the prescribed protocols...2-20-10.		

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I 229	Continued From page 7 b. if [the resident] does not eat after 3-5 minutes of food being served, staff should provide verbal prompts; c. if [the resident] does not eat after 5-10 minutes, staff should provide hand over hand assistance; d. if [the resident] declines staff should feed her; e. if [the resident] attempts to hand mouth, staff should use gentle physical and verbal prompts to redirect her back to eating; f. allow [the resident] extended time to complete her meal (30-45 minutes); and, g. if [the resident] declines to finish her entire meal provide fluids and supplements and document intake. On December 18, 2009, beginning at approximately 11:00 a.m., review of staff in-service training records revealed that the staff who were observed assisting Resident #3 at breakfast had received training on October 2, 2009. Observations on December 16, 2009, however, indicated that the training had not been effective.	I 229		
I 372	3519.3 EMERGENCIES Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP	I 372		

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1372	<p>Continued From page 8</p> <p>failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.</p> <p>The findings include:</p> <p>1. On December 17, 2009 at 9:17 a.m., there was no list of emergency contact numbers posted near the telephone located in the dining area. The qualified mental retardation professional (QMRP) acknowledged there was no list nearby. She immediately retrieved an emergency contact list from elsewhere and posted it near the telephone.</p> <p>2. On the following day, December 18, 2009, observations at 9:58 a.m. revealed that there was no list of emergency numbers posted near the three telephones on the upper level. The QMRP, who was present at the time, acknowledged that there were no emergency numbers posted. She retrieved two emergency contact lists from elsewhere and posted them near the telephone in her office and the telephone nearest the medication cabinet. However, at the close of the survey later that day, there was no emergency contact list posted next to the third telephone located upstairs in the facility (in the 'central' nurses office).</p>	1372	<p>3519.3</p> <p>Emergency contact lists are posted at every phone area...2-1-10 The facility manager will audit the concern during routine, bimonthly, environmental reviews and will follow up as needed...2-4-10.</p>	
1422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record</p>	1422		

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I 422	<p>Continued From page 9</p> <p>verification, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement habilitation and training programs in accordance with their Individual Support Plan, for two of the three residents in the sample. (Residents #2 and #3)</p> <p>The findings include:</p> <p>On December 16, 2009, Resident #2 was observed at her day program from 11:25 a.m. until 12:15 p.m.</p> <p>1. At 11:44 a.m., direct support staff could not locate Resident #2's communication device. According to both the direct support staff and the day program case manager who were present, the home had not been secured: the device in the resident's backpack as required. They presented program data sheets from November and December 2009, on which staff had documented that the communication device had been available on November 2nd and 3rd and on December 2nd and 4th but was unavailable on all other days during those periods. The case manager then presented an Intra-Agency Communication note, dated November 23, 2009, in which the day program alerted the home to the problem.</p> <p>2. At 11:57 a.m., a direct support staff person presented a lunch plate that consisted of pureed chicken, peas and other foods. The staff placed an angled spoon into the resident's left hand and immediately began providing her with hand-over-hand assistance as she ate her first mouthfuls. The staff continued providing hand-over-hand assistance for the remainder of the meal. Earlier that day, however, Resident #2 had been observed feeding herself breakfast,</p>	I 422	<p>3521.3</p> <ol style="list-style-type: none"> Staff received additional training from the QMRP on 12-18-09 to insure they understood the importance of taking Client #2's communication device to the day program consistently. The QMRP discussed the issue with the day program and agreed to use a formal documentation process (a standard sign off form) to verify receipt of the communication device daily as well as daily pick up by the residential staff. The facility manager and QMRP will routinely check the forms to insure that staff is consistently providing the device and bringing it home daily...2-9-10. The QMRP discussed the feeding concern (Client #2) with the day program and provided the day program with a new copy of the prescribed feeding protocol. Client #2 can eat independently using the adaptive spoon prescribed for her and should be allowed to do so daily at all meals. The QMRP and facility manager will insure that meal observations are done during routine, monthly visits to the program to insure ongoing compliance by the day program staff...2-5-10. 	

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1422	<p>Continued From page 10</p> <p>while using the adaptive spoon.</p> <p>3. During the meal (at 12:03 p.m.), it was observed that the resident's wheelchair safety harness was not properly secured. The harness strap was draped loosely across her elbow region rather than fastened properly down her shoulder and chest.</p> <p>While still at the day program, at 12:38 p.m., review of Resident #2's "Annual Summary, dated June 2009, revealed that the resident was "dependent upon staff to perform all activities of daily living except self-feeding. <Resident's name> requires staff supervision during meals... My ultimate vision: to increase my independence..."</p> <p>4. The qualified mental retardation professional (QMRP) was interviewed the next day (December 17, 2009) at approximately 9:20 a.m. She stated that Resident #2 was generally able to feed herself with the angled spoon. Staff would only provide hand-over-hand assistance if necessary. The QMRP further indicated that she had visited Resident #2's day program; however, she could not recall whether that had included a mealtime observation.</p> <p>5. On December 17, 2009, at 4:10 p.m., the QMRP was interviewed further, along with the house manager (HM) and the RN. All three concurred that the resident's safety harness should be secured across her chest and shoulders at all times while she is seated in her wheelchair. They all agreed that staff should allow Resident #2 to feed herself using the adaptive spoon.</p> <p>6. On December 18, 2009, at approximately 9:20</p>	1422	<p>3. The QMRP will meet with day program staff for Client #2 to insure they understand how to properly use the harness and will offer to train staff on its use...2-18-10.</p> <p>Additionally, the QMRP will monitor compliance during her monthly visits to the program as will the facility manager during periodic visits...2-5-10.</p>	

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1422	<p>Continued From page 11</p> <p>a.m., the QMRP and HM were asked about Resident #2's communication device. Neither was aware that the resident had been without the device at her day program on the day before. The HM presented the device and then demonstrated how it should be used. She and the QMRP indicated that the overnight shift staff were expected to place the communication device in Resident #2's backpack and the day shift staff were to verify that it was in her bag before leaving for day program. The HM further stated that she spoke with staff after receiving the November 23, 2009 note from the day program. Further interview, however revealed that neither she nor the QMRP had been monitoring since then to ensure that the resident had her device with her and/or that her communication program was being implemented at the day program.</p> <p>7. On December 16, 2009 7:35 a.m., Resident #3 was observed with gloves on her hands and tape wrapped around each wrist. At 7:52 a.m., the resident was observed removing the gloves and sticking her hands into her mouth. At 8:00 a.m., the direct support staff was observed taking the resident to the bathroom, washing her hands and replacing the gloves onto her hands. At 8:02 a.m., the resident removed the gloves and began sticking her hands in her mouth again. At 8:04 a.m., the direct care staff adjusted the glove on the resident's right hand, only. The left hand remained without a glove. At 8:15 a.m., the resident was observed sticking both hands into her mouth. The direct care staff was heard asking the resident to "remove your hands from your mouth."</p> <p>During the entrance conference on December 16, 2009, beginning at 9:25 a.m., the qualified mental retardation professional (QMRP) and house</p>		1422		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H ID03-0181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2009
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT (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
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1422	Continued From page 12 manager (HM) revealed that Resident #3 had a Behavior Support Plan (BSP) to address hand mouthing. Further interview indicated the resident used hand mittens to maintain healthy hand skin. Review of the Resident #3's clinical record on December 18, 2009, at 10:32 am., revealed a BSP dated June 13, 2009. The BSP had a targeted behavior of self-stimulatory hand mouthing. The BSP revealed the following procedures to address the behavior: - provide verbal redirection - if [the resident] begins to hand mouth, redirect her to a sensory "schedule activity" with one to one supervision; - provide materials or gentle body movement; - engage [the resident] for 10-15 minutes; - gently assist [the resident] by taking her hands out of the mouth; - offer [the resident] items to hold, place headphones on her, - if [the resident] continues to hand mouth for 30 minutes, place the gloves on her hands and direct her to an activity with physical movement; - remove the gloves after 15 minutes and offer activities again; and, - alternate periods of gloves on if [the resident] is persistent with gloves off and interventions. On December 16, 2009, facility staff failed to	1422		
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1422	<p>Continued From page 13</p> <p>Implement Resident #3's B SP as instructed.</p> <p>8. The facility failed to obtain a safety, chest harness for Resident #1's wheelchair in accordance with physician's orders, as follows:</p> <p>On December 17, 2009, at approximately 2:12 p.m., review of Resident #1's physical therapy records revealed a note dated June 12, 2009, in which the PT indicated that the resident needed a "new chest harness" for his wheelchair. The resident, however, had not been observed wearing a chest harness during the first day of this survey. On December 17, 2009, at 3:48 p.m., the HM, QMRP and the RN stated that Resident #1's wheelchair did not require a harness. At 4:27 p.m., the QMRP acknowledged the June 12, 2009 PT note then stated that she thought this issue had "been resolved" since that time. The QMRP could not, however, locate a PT note or other form of documentation to substantiate that the harness was no longer needed.</p> <p>On December 18, 2009, at 1:07 p.m., review of Resident #1's physician's orders (POs) revealed that on February 12, 2009, the primary care physician (PCP) wrote an order to "Add harness to wheelchair to prevent him from falling out." Further review of the POs, followed by additional interviews with the QMRP and RN revealed no evidence that the PCP had discontinued the February 12, 2009 order.</p> <p>9. The facility failed to implement a system that ensured effective monitoring of Resident #1's safety helmet, as follows:</p> <p>On December 16, 2009, at 9:06 a.m., staff placed a safety helmet on Resident #1's head, as he</p>	1422		

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
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1422	<p>Continued From page 14</p> <p>prepared to leave for day program. The helmet had a large (approximately 2-inch) crack visible on the front, right area. When asked, neither of the two direct support staff persons there with him had previously noticed the crack.</p> <p>On December 17, 2009, beginning at approximately 3:33 p.m., the house manager (HM), qualified mental retardation professional (QMRP) and the RN were interviewed together. All three stated that they were previously unaware that Resident #1's helmet was cracked. Staff had not informed them of the cracking observations on the previous day. They said that the strap on his helmet had "just come loose about two weeks" prior to this survey, and the HM reportedly had ordered a new strap. At 6:02 p.m., the RN inspected the helmet and confirmed the crack on the front. She also identified another crack that was on the back of the helmet.</p> <p>On December 18, 2009, at approximately 10:00 a.m., the QMRP presented a checklist from Resident #1's program box a daily accounting of the resident's adaptive equipment. Review of the checklist revealed that direct support staff had documented that the helmet was in good repair on every day thus far in December, including the past three mornings. The QMRP and the HM acknowledged that the damaged helmet (strap or cracks) on the checklist. Neither of them knew how long ago the cracks first appeared on the helmet and they had not verified the accuracy of the data on the checklist prior to this survey.</p> <p>10. The facility failed to maintain Resident #3's wheelchair in good repair, as follows:</p>	1422	<p>The QMRP will conduct a training session with staff on the proper implementation of Client #3's BSP by...2-5-10. Psychology will provide further training by...2-20-10. Additionally, the QMRP and facility manager will conduct routine weekly observations to insure that staff follows the BSP when the hand-to-mouth behavior presents itself...2-15-10.</p> <p>The QMRP and facility manager will provide on-the-spot training when they observe improper implementation of the BSP strategies and will document the training for the record...2-15-10.</p> <ol style="list-style-type: none"> 1. A new harness has been ordered for Client #1 but the individual's Gait Belt will be used in the interim...2-5-10. 2. A new helmet has been obtained for Client #1...2-1-10 3. A new wheelchair had been requested for Client #3 via the 719A process prior to the survey but has not yet been approved. MTS is awaiting response from Medicaid/Medicare and will follow up as indicated once feedback is obtained. The QMRP and RN will follow up until the new wheelchair is obtained and will document progress in their monthly notes...2-20-10. <p>The QMRP and RN separately will check the needed adaptive equipment monthly to insure that it is in good repair and in working order...2-10-10. The facility manager and staff will continue their routine checks and reporting process but the more professional oversight of the QMRP and RN will increase the likelihood of spotting concerns in a timely manner and initiating appropriate follow up...2-15-10.</p>	

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I 422	Continued From page 15		I 422		
	On December 16, 2009, at approximately 7:40 a.m., Resident #3 was observed in her wheelchair. The left side of the armrest was observed torn and worn down, exposing the metal framework. Interview with the QMRP on December 16, 2009, at approximately 3:30 p.m., revealed that she had no knowledge of the worn armrest. Review of the resident's adaptive equipment checklist on December 18, 2009, at 10:00 a.m., revealed that staff had been documenting that the wheelchair was in good repair.				
I 484	3522.11 MEDICATIONS		I 484		
	Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.			3522.11	
	This Statute is not met as evidenced by: Based on observation and record review, the facility's nurse failed to remove from use, outdated controlled substances medications, for one of three residents in the sample (Resident #3)			The expired medication has been properly disposed of...2-1-10. The medication cabinet will be audited at minimum twice monthly by the RN or the administrative support LPNs to insure that expired medications are disposed of in a timely manner...2-5-10. Quarterly reviews with the pharmacist are also completed to insure expired medications are properly disposed of and the facility manager audits topical creams applied with (direct support professional) staff support bimonthly...2-5-10.	
	The finding includes: On December 16, 2009, at 4:50 p.m., during an inspection of the medication cabinet, a bottle holding two Lorazepam 2mg pills was observed in a plastic bag. The label on the bottle indicated an expiration date of June 19, 2009. The Licensed Practical Nurse on duty at that time examined the label and confirmed that the medication had expired.				
	At the time of the survey, there was no evidence that the facility's nursing staff ensured that				

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1484	Continued From page 16 expired medications were removed from the clients' supplies after the expiration date.	1484		
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for three of the three residents in the sample. (Residents #1, #2, and #3) The findings include: 1. The GHMRP failed to establish a system that would ensure residents and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three residents in the sample. (Resident #1) During the morning medication pass observed on December 16, 2009, Resident #1 was administered Risperdal 1 mg at approximately 7:30 a.m. During the entrance conference a short while later, at approximately 9:30 a.m., the QMRP and house manager HM indicated that Resident #1's Risperdal was incorporated in his behavior support plan (BSP). They further indicated that his sister was his designated	1500	3523.1 The sister of Client #1 will have the accurate Risperdal regimen reviewed with her and have the risks/benefits discussion once again in order to obtain proper, informed consent for the regimen. This review will occur by...2-14-10. In the future, the RN and QMRP separately will audit the forms to insure they are completed accurately and fully...2-14-10.	

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I 500	<p>Continued From page 17</p> <p>surrogate health care decision-maker.</p> <p>On December 17, 2009, at 11:14 a.m., review of Resident #1's Individual Support Plan dated July 29, 2009, revealed that the resident was not competent to make health care or financial decisions and "has a sister who signs medical consents for his medical issues as needed." Further review of Resident #1's record failed to show evidence that the sister had been fully informed of the resident's mental health status and the risks and benefits associated with the use of Risperdal. She had not signed the attendance sheet for his ISP meeting and there was no written consent for the use of Risperdal observed in his record.</p> <p>On December 18, 2009, at 1:10 p.m., review of Resident #1's POs revealed that he had previously been taking Risperdal 1 mg twice daily, as well as Klonopin. His record indicated that he was hospitalized between June 11-24, 2008, during which time they discontinued both medications. The POs reflected that Resident #1 remained off of both medications for approximately 8 months after being readmitted to the facility on June 24, 2008.</p> <p>Subsequent review of Resident #1's Psychotropic Medication Reviews revealed that he had been "stable, redirectable" and "otherwise "doing well off medications" until February 2009, at which time he had a spike in incidents of physical aggression. On February 24, 2009, the psychiatrist prescribed a resumption of Risperdal.</p> <p>At 1:41 p.m., the QMRP was asked when the sister had been informed of Resident #1's behavioral changes and the psychiatrist's recommendation that he resume taking</p>	I 500		

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1500	<p>Continued From page 18</p> <p>Risperdal. She acknowledged that the facility contacted the sister on the day before (December 17, 2009) and discussed the issues. She then presented a consent form that the sister had signed December 17, 2009, for 1 mg Risperdal daily. [Note: The resident was actually receiving 1 mg twice daily, two times the dosage represented on the consent form.] The QMRP acknowledged that the facility had not informed the sister timely.</p> <p>2. Cross-refer to 1422.1-.6. The GHMRP failed to ensure that Resident #2 received habilitation, training and support in accordance with her Individual Support Plan. Specifically, day program staff did not implement her communication program, did not provide an appropriate level of assistance during her meals, and failed to ensure continuous wheelchair safety.</p> <p>3. Cross-refer to 1422.7. The GHMRP failed to ensure that Resident #3 received habilitation, training and support in accordance with her behavior support plan.</p> <p>4. Cross-refer to 1422.8-.10. The facility failed to establish a system that ensured provision of, and the timely maintenance of residents' adaptive and assistive devices, for two of the three residents in the sample. (Residents #1 and #3)</p>	1500	<p>See responses for 1422.1-6, 1422.7 and 1422.8-10</p>	

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R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from December 16, 2009 through December 18, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of four female residents and one male resident with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.</p>	R 000		
R 122	<p>4701.2 BACKGROUND CHECK REQUIREMENT</p> <p>Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person, for 3 out of 12 direct support staff employed. (S6, S8 and S8).</p> <p>The findings include:</p> <p>On December 16, 2009, at approximately 10:15 a.m., the house manager (HM) and qualified mental retardation professional agreed to make available for review, the personnel records for all employees and consultants, including evidence of</p>	R 122	<p>R122</p> <p>MTS uses Century Link for its criminal background checks, which is a global check and not a local one. The 2009 hires mentioned were checked through Century Link (See: attached copies). The three older staff members cited will be redone via Century Link...2-5-10.</p>	

HEALTH REGULATION ADMINISTRATION	PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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R 122	Continued From page 1 criminal background checks for all staff employed in the facility. Review of the personnel records on December 17, 2009, beginning at 4:57 p.m., revealed no documentation available to verify that a background check had been obtained prior to employment for the following direct support staff: a. S5 (hired in October 2009); b. S6 (employment application signed October 6, 2009); and, c. S8 (employment application signed January 26, 2009). At 6:36 p.m., the HM said she would ask their corporate office for additional documentation. No additional information was provided before the survey ended the following day. It should be noted that there were 3 other direct support staff (S1, S2 and S3) for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which	R 125		

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R 125	<p>Continued From page 2</p> <p>the employees had worked or resided within the 7 years prior to the check, for 3 out of 9 direct support staff whose background check documentation was made available for review. (S1, S2 and S4)</p> <p>The findings include:</p> <p>On December 16, 2009, at approximately 10:15 a.m., the house manager (HM) and qualified mental retardation professional agreed to make available for review the personnel records for all employees and consultants, including evidence of criminal background checks for all staff employed in the facility. Review of the personnel records on December 17, 2009, beginning at 4:57 p.m., revealed no documentation available to verify that a background check had been obtained prior to employment for 3 out of 11 direct support staff. Of the 9 employees whose background check information was provided for review, 3 of those 9 were not comprehensive, as follows:</p> <ol style="list-style-type: none"> 1. A background check had been requested in the District of Columbia for S1 on January 14, 2004. The request form, however, did not reflect the results of the search. There was no evidence presented that a comprehensive background check had been completed. 2. A District of Columbia background check had been documented for S2. However, her personnel records indicated that she lived in Maryland when she applied for employment in 2003. There was no evidence that a background check had been obtained in that jurisdiction. 3. A District of Columbia background check had been documented on July 29, 2009 for S4. However, her personnel record indicated that she 	R 125		

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

ID003-0181

(X2) MULTIPLE CONSTRUCTION
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(X3) DATE SURVEY COMPLETED

12/18/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MULTI-THERAPEUTIC SERVICES, INC

4414-16 JAY STREET NE
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R 125	<p>Continued From page 3</p> <p>was employed in Montgomery County, MD (elderly care) from August 2009 until she applied for employment on September 21, 2009. There was no evidence that a background check had been obtained in that jurisdiction.</p> <p>At 6:36 p.m., the HM said she would ask their corporate office for additional documentation. No additional information was provided before the survey ended the following day.</p>	R 125		