

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

PRINTED: 04/28/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>04/23/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5610 FIRST STREET NW WASHINGTON, DC 20011</b>
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{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>A revisit survey was conducted on April 22, 2009 through April 23, 2009. The Plan of Correction for the September 5, 2008 recertification survey, which was submitted by the facility on October 10, 2008, was the focus of this revisit survey. The facility provided services and supports for four males with various disabilities.</p> <p>The findings of the survey were based on observations, interviews with administrative and direct care staff, as well as a review of client and administrative records, including unusual incident reports.</p> <p>The results of the survey determined the facility maintained compliance with the previously cited deficiencies, however, there were standard level deficiencies.</p>	{W 000}	<p><i>Received 5/19/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
{W 104}	<p><b>483.410(a)(1) GOVERNING BODY</b></p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas for one of the two clients (Client #1) included in the sample.</p> <p>The findings include:</p> <p>Cross-refer to W149. The governing body failed to implement policies that ensured the client's health and safety.</p>	{W 104}	<p><b>Cross reference W149</b></p>	<p><b>5/6/09</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Constantine A. Reese Program Director* **5-6-09**

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 104}  W 149	<p>Continued From page 1</p> <p>This is a repeat deficiency. See Federal Deficiency Report dated September 5, 2008. 483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the two clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to implement their Incident Management Policy as evidenced below:</p> <p>Review of the facility's incident reports on April 22, 2009, beginning at 5:24 PM revealed an incident dated December 6, 2008, involving Client #1. According to the report, staff observed [Client #1] "attempting to lie down on the sofa in the dining room and hitting his lip on the wooden arm of the furniture." Further review of the incident report revealed the client sustained a cut on his upper lip. On December 10, 2008, Client #1 "woke up in the middle of night (2:50 AM), came downstairs and sat down on the sofa in the dining room. Review of the incident report revealed that at 2:56 AM, the direct care staff discovered a cut over the client's right eye. Continued review of the incident report revealed Client #1 was taken to the emergency room where he was diagnosed with a laceration to his face. It should be noted that the resident</p>	{W 104}  W 149	<p>In the future, all recommendations given in investigation reports will be implemented in a timely manner to ensure the safety of all individuals. The Program Director will be given a written request to instruct Maintenance Supervisor to remove all furniture or items that can cause a safety hazard.</p>	5/6/09
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W 149	<p>Continued From page 2</p> <p>received stitches and was discharged from the hospital later that afternoon.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on April 23, 2009, was conducted to ascertain information regarding the facility's policies and procedures for reporting/investigating incidents. The surveyor was provided a copy of the incident management policy for review. Review of the policy revealed a section entitled "Procedure." Further review of this section of the policy revealed that the QMRP and Residential Manager would investigate all reportable incidents. Additionally, "all incidents (reportables) would include findings and recommendations."</p> <p>Interview with the facility's Residential Manager (RM) on April 22, 2009, revealed that she had conducted internal investigations for the aforementioned incidents. Review of the investigative report dated December 8, 2008, (for the incident dated December 6, 2008), revealed a recommendation for the facility's program director to have the dining room sofa removed from the group home. The investigative report dated December 10, 2008, ( for the incident on December 10, 2008) revealed the same recommendation for the dining room sofa to be removed from the facility was made. It should be noted that the dining room sofa had not been removed from the facility until the day of the survey (April 23, 2009), at approximately 10:00 AM.</p> <p>At the time of the survey, the facility failed to implement the recommendations that were made to ensure Client #1's safety.</p>	W 149		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/23/2009
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{1 000}	INITIAL COMMENTS  A revisit licensure survey was conducted on April 22, 2009 through April 23, 2009. The Plan of Correction for the September 5, 2008 recertification survey, which was submitted by the facility on October 10, 2008, was the focus of this revisit survey. The facility provided services and supports for four males with various disabilities.  The findings of the survey were based on observations, interviews with administrative and direct care staff, as well as a review of client and administrative records, including unusual incident reports.  The results of the survey determined the facility maintained compliance with the previously cited deficiencies.	{1 000}		

Health Regulation Administration

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

TITLE *Program Director* (X6) DATE *5-6-09*

STATE FORM

6896

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If continuation sheet 1 of 1