

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

PRINTED: 09/22/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/25/2009
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS The State agency received an unusual incident report on July 14, 2009. The facility reported that Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom. Within a few minutes later, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment. An onsite investigation was conducted on August 25, 2009 to verify compliance with federal participation requirements in the condition of client protection and active treatment. The results of the investigation were based on interviews with direct care staff, nursing and administrative staff. Also the findings were based on the review of the client's medical records and the facility's administrative records; including incident reports.	W 000	<p><i>Received 10/8/09</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 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the	W 159			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Caroline A. Reese* TITLE: *Program Director* (X6) DATE: *10/8/09*

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 159	Continued From page 1 Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen for one of the six client's in the facility. (Client #1) The findings include: 1. The QMRP failed to ensure that staff implemented the agency's incident reporting system in accordance with the agency's policy. (See W153) 2. The QMRP failed to ensure that staff training was effective. (See W189)	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for two of the six clients residing in the facility. (Client's #1 and #2) The finding includes: The facility failed to have effective training on Client #1's behavior support interventions as evidenced below: On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed	W 189	1. The staff will receive adequate training from the QMRP and Residential Manager on the policy and procedures for Incident Management and reporting incidents in a timely manner. 2. The QMRP will give the staff a comprehensive assessment after the training to ensure that the staff training was effective.	10/23/09	10/23/09

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W 189	<p>Continued From page 2</p> <p>the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>Review of Client #1's Behavior Support Plan dated May 27, 2009 in the Interventions section for Safety Zone indicated the following:</p> <p>"A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress."</p> <p>2. The facility failed to ensure effective training on completing and reporting unusual incident reports as evidenced below:</p> <p>On August 25, 2009 at 1:45 PM, interview with the Residential Manager (RM) and the review of the facility's internal investigative reports revealed the facility staff had failed to report all incidents as evidenced below:</p> <p>On July 18, 2009 client #1 was discovered at 11:20 PM by staff in client #2's bed. Review of the group home's internal investigation revealed that Client #1 was discovered with her finger inserted into client #2's rectum.</p> <p>Interview with the RM on August 25, 2009 revealed that staff heard Client #2 yelling out</p>	W 189	<p>2. Cross reference W159</p>	10/23/09
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W 189	Continued From page 3 loudly on the night of the incident and went to her bedroom. However, the investigative report did not specify what staff did to intervene and assist the client once she discovered Client #1 in the bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her findings. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later. Reportedly the staff informed the RM that she had not encountered a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock or on a 24 hour basis.	W 189		
W 193	Review of the in-service training log book revealed that the agency had trained all staff January 2009 and July 2009 on the agency's incident management system. This training was not effective. 483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility staff failed to demonstrate competency in the implementation of Behavior Support Plan's (BSP) for one of the six clients residing in the facility. (Clients #1) The finding includes: The facility failed to ensure that Client #1's	W 193		

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W 193	<p>Continued From page 4</p> <p>Behavior Support Plan was implemented as written as evidenced below:</p> <p>On July 15, 2009, the State Agency received written notification of an incident from this agency. Reportedly on July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>On the same day, the review of Client #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions were to occur as follows:</p> <ol style="list-style-type: none"> 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergencies request for assistance and implementation of the agency's policies and procedures. 	W 193	<p>Staff will receive additional training from the psychologist on Client #1's Behavior Support Plan.</p>	10/23/09	

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W 193	Continued From page 5 According to the incident report Staff #1 "blocked" Client #1 in her bedroom and the client's behavior escalated. Reportedly, staff were trained on the implementation of Client #1's behavior support plan and interventions on July 31, 2009. The BSP noted specifically in the Safety Zone intervention the following: "A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress." It should be noted that Client #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.	W 193		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for one of the six client's residing in the facility. (Clients #1) The finding includes: The facility staff failed to appropriately implement	W 249		

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W 249	<p>Continued From page 6</p> <p>Client #1's Behavior Support Plan (BSP) Interventions as evidenced below:</p> <p>On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to blocked her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>Review of Client #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions were to occur as follows:</p> <ol style="list-style-type: none"> 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergencies request for assistance and implementation of the agency's policies and procedures. <p>The BSP noted specifically in the Safety Zone intervention the following:</p>	W 249	Cross reference W193	10/23/09	

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W 249	<p>Continued From page 7</p> <p>"A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress."</p> <p>It should be noted that Client #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.</p>	W 249		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2009
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I 000	<p>INITIAL COMMENTS</p> <p>The State agency received an unusual incident report on July 14, 2009. The facility reported that Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom. Within a few minutes later, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>An onsite investigation was conducted on August 25, 2009 to verify compliance with federal participation requirements in the condition of client protection and active treatment.</p> <p>The results of the investigation were based on interviews with direct care staff, nursing and administrative staff. Also the findings were based on the review of the client's medical records and the facility's administrative records; including incident reports.</p>	I 000		
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I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively,</p>	I 222	Cross reference W193	10/23/09
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Health Regulation Administration
Catherine A. Reese LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Gregory Director TITLE
 (X6) DATE 10/8/09

Health Regulation Administration

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I 222	Continued From page 1 efficiently and competently for two of the six clients residing in the facility. (Client's #1 and #2) The finding includes: The facility failed to have effective training on Client #1's behavior support interventions as evidenced below: On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment. Review of Client #1's Behavior Support Plan dated May 27, 2009 in the Interventions section for Safety Zone indicated the following: "A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress." 2. The facility failed to ensure effective training on completing and reporting unusual incident reports as evidenced below: On August 25, 2009 at 1:45 PM, interview with the Residential Manager (RM) and the review of the facility's internal investigative reports revealed the facility staff had failed to report all incidents as	I 222	2. Cross reference W159	10/23/09

Health Regulation Administration

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I 222	Continued From page 2 evidenced below: On July 18, 2009 client #1 was discovered at 11:20 PM by staff in client #2's bed. Review of the group home's internal investigation revealed that Client #1 was discovered with her finger inserted into client #2's rectum. Interview with the RM on August 25, 2009 revealed that staff heard Client #2 yelling out loudly on the night of the incident and went to her bedroom. However, the investigative report did not specify what staff did to intervene and assist the client once she discovered Client #1 in the bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her findings. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later. Reportedly the staff informed the RM that she had not encountered a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock or on a 24 hour basis. Review of the in-service training log book revealed that the agency had trained all staff January 2009 and July 2009 on the agency's incident management system. This training was not effective.	I 222		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by:	I 422	Cross reference W193	10/23/09

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I 422	<p>Continued From page 3</p> <p>Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the six residents residing in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that Resident #1's Behavior Support Plan (BSP) was implemented as written as evidenced below:</p> <p>On July 15, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on July 14, 2009. At approximately 8:30 PM, Staff #1 reported that Resident #1 said that she wanted to leave the group home and was observed leaving out the front door. Staff #1 and Staff #2 escorted the resident back into the group home and Resident #1 retreated to her bedroom.</p> <p>Reportedly, Resident #1 again began to say she was leaving the and Staff #1 blocked the door way to her bedroom and Resident #1 is unable to get out of the bedroom. Resident #1 became upset and threw a radio at Staff #1. Staff #1 called for assistance from other staff on duty. Resident #1's behavior escalated and she began to throw, bang and knock over furniture in her bedroom. All three direct care staff attempt to intervene without success. Staff #2 called 911 and notified the House Manager. According to the report the D.C. Metropolitan Police arrived at the group home at approximately 8:45 p.m. It was decided that Staff #2 would escort Resident #1 to the CPEP for emergency evaluation and treatment.</p>	I 422		

Health Regulation Administration

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I 422	Continued From page 4 Review of Resident #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions are to occur as follows: 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergency, request for assistance and implementation of the agency's policies and procedures. According to the incident report Staff #1 blocked Resident #1 in her bedroom and the resident's behavior escalated. Reportedly, staff were trained on the implementation of Resident #1's behavior support plan and interventions on July 31, 2009. The BSP noted specifically in the Safety Zone intervention the following: "A safety zone is not seclusion. [The Resident] should never be locked in any room or denied egress." It should be noted that Resident #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.	I 422		



COMMUNITY MULTI-SERVICES, Inc.

1300 Spring Street
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Telephone: (301) 588-9280

Facsimile: (301) 588-9287

FACSIMILE TRANSMISSION COVER SHEET

Date: 10/8/09

Time: 12:41 am (6)

To:

Name: Ms. Mebane

Firm: HLA

Phone Number: _____

Fax Number: 2-442-9430

From: Constance A. Reese, Program Director

Number of pages including this one: 14

Subject: _____

IN THE EVENT OF AN ERROR IN TRANSMISSION, PLEASE ADVISE BY TELEPHONE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/25/2009
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The State agency received an unusual incident report on July 14, 2009. The facility reported that Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom. Within a few minutes later, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>An onsite investigation was conducted on August 25, 2009 to verify compliance with federal participation requirements in the condition of client protection and active treatment.</p> <p>The results of the investigation were based on interviews with direct care staff, nursing and administrative staff. Also the findings were based on the review of the client's medical records and the facility's administrative records; including incident reports.</p>	W 000		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews with the</p>	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Courtney A. Reese* TITLE: *Program Director* (X6) DATE: *10/8/09*

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 159	Continued From page 1 Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen for one of the six client's in the facility. (Client #1) The findings include: 1. The QMRP failed to ensure that staff implemented the agency's incident reporting system in accordance with the agency's policy. (See W153) 2. The QMRP failed to ensure that staff training was effective. (See W189)	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for two of the six clients residing in the facility. (Client's #1 and #2) The finding includes: The facility failed to have effective training on Client #1's behavior support interventions as evidenced below: On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed	W 189	1. The staff will receive adequate training from the QMRP and Residential Manager on the policy and procedures for Incident Management and reporting incidents in a timely manner. 2. The QMRP will give the staff a comprehensive assessment after the training to ensure that the staff training was effective.	10/23/09	10/23/09

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W 189	<p>Continued From page 2</p> <p>the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>Review of Client #1's Behavior Support Plan dated May 27, 2009 in the Interventions section for Safety Zone indicated the following:</p> <p>"A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress."</p> <p>2. The facility failed to ensure effective training on completing and reporting unusual incident reports as evidenced below:</p> <p>On August 25, 2009 at 1:45 PM, interview with the Residential Manager (RM) and the review of the facility's internal investigative reports revealed the facility staff had failed to report all incidents as evidenced below:</p> <p>On July 18, 2009 client #1 was discovered at 11:20 PM by staff in client #2's bed. Review of the group home's internal investigation revealed that Client #1 was discovered with her finger inserted into client #2's rectum.</p> <p>Interview with the RM on August 25, 2009 revealed that staff heard Client #2 yelling out</p>	W 189	2. Cross reference W159	10/23/09	

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W 189	Continued From page 3 loudly on the night of the incident and went to her bedroom. However, the investigative report did not specify what staff did to intervene and assist the client once she discovered Client #1 in the bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her findings. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later. Reportedly the staff informed the RM that she had not encountered a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock or on a 24 hour basis.	W 189			
W 193	Review of the in-service training log book revealed that the agency had trained all staff January 2009 and July 2009 on the agency's incident management system. This training was not effective. 483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility staff failed to demonstrate competency in the implementation of Behavior Support Plan's (BSP) for one of the six clients residing in the facility. (Clients #1) The finding includes: The facility failed to ensure that Client #1's	W 193			

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W 193	<p>Continued From page 4</p> <p>Behavior Support Plan was implemented as written as evidenced below:</p> <p>On July 15, 2009, the State Agency received written notification of an incident from this agency. Reportedly on July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>On the same day, the review of Client #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions were to occur as follows:</p> <ol style="list-style-type: none"> 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergencies request for assistance and implementation of the agency's policies and procedures. 	W 193	<p>Staff will receive additional training from the psychologist on Client #1's Behavior Support Plan.</p>	10/23/09	

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W 193	<p>Continued From page 5</p> <p>According to the incident report Staff #1 "blocked" Client #1 in her bedroom and the client's behavior escalated. Reportedly, staff were trained on the implementation of Client #1's behavior support plan and interventions on July 31, 2009. The BSP noted specifically in the Safety Zone intervention the following:</p> <p>"A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress."</p> <p>It should be noted that Client #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.</p>	W 193		
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 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 staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for one of the six client's residing in the facility. (Clients #1)</p> <p>The finding includes:</p> <p>The facility staff failed to appropriately implement</p>	W 249		

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W 249	<p>Continued From page 6</p> <p>Client #1's Behavior Support Plan (BSP) Interventions as evidenced below:</p> <p>On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to blocked her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>Review of Client #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions were to occur as follows:</p> <ol style="list-style-type: none"> 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergencies request for assistance and implementation of the agency's policies and procedures. <p>The BSP noted specifically in the Safety Zone intervention the following:</p>	W 249	Cross reference W193	10/23/09	

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W 249	<p>Continued From page 7</p> <p>"A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress."</p> <p>It should be noted that Client #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.</p>	W 249		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2009
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1 000	<p>INITIAL COMMENTS</p> <p>The State agency received an unusual incident report on July 14, 2009. The facility reported that Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom. Within a few minutes later, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment.</p> <p>An onsite investigation was conducted on August 25, 2009 to verify compliance with federal participation requirements in the condition of client protection and active treatment.</p> <p>The results of the investigation were based on interviews with direct care staff, nursing and administrative staff. Also the findings were based on the review of the client's medical records and the facility's administrative records; including incident reports.</p>	1 000		
1 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively,</p>	1 222	Cross reference W193	10/23/09

Health Regulation Administration
Christine A. Reese LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Prayam Director TITLE
 (X6) DATE: 10/8/09

Health Regulation Administration

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I 222	Continued From page 1 efficiently and competently for two of the six clients residing in the facility. (Client's #1 and #2) The finding includes: The facility failed to have effective training on Client #1's behavior support interventions as evidenced below: On July 14, 2009 Client #1 eloped from the facility at approximately 8:30 p.m. Staff followed the client and was successful in escorting her back to the facility. She retreated to her bedroom and within a few minutes, the client stated she wanted to leave the facility again. Staff stood in the entry way of her bedroom, to deter her from leaving. As a result, the client became upset and threw a radio at staff. Additional staff responded, however the client's behavior escalated that resulted in 911 being called. The D.C. Metropolitan Police arrived at approximately 8:45 PM and escorted the client to CPEP for emergency evaluation and treatment. Review of Client #1's Behavior Support Plan dated May 27, 2009 in the Interventions section for Safety Zone indicated the following: "A safety zone is not seclusion. [The Client] should never be locked in any room or denied egress." 2. The facility failed to ensure effective training on completing and reporting unusual incident reports as evidenced below: On August 25, 2009 at 1:45 PM, interview with the Residential Manager (RM) and the review of the facility's internal investigative reports revealed the facility staff had failed to report all incidents as	I 222	2. Cross reference W159	10/23/09

Health Regulation Administration

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I 222	Continued From page 2 evidenced below: On July 18, 2009 client #1 was discovered at 11:20 PM by staff in client #2's bed. Review of the group home's internal investigation revealed that Client #1 was discovered with her finger inserted into client #2's rectum. Interview with the RM on August 25, 2009 revealed that staff heard Client #2 yelling out loudly on the night of the incident and went to her bedroom. However, the investigative report did not specify what staff did to intervene and assist the client once she discovered Client #1 in the bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her findings. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later. Reportedly the staff informed the RM that she had not encountered a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock or on a 24 hour basis. Review of the in-service training log book revealed that the agency had trained all staff January 2009 and July 2009 on the agency's incident management system. This training was not effective.	I 222			
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by:	I 422	Cross reference W193	10/23/09	

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1422	Continued From page 3 Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the six residents residing in the facility. (Resident #1) The finding includes: The facility failed to ensure that Resident #1's Behavior Support Plan (BSP) was implemented as written as evidenced below: On July 15, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on July 14, 2009. At approximately 8:30 PM, Staff #1 reported that Resident #1 said that she wanted to leave the group home and was observed leaving out the front door. Staff #1 and Staff #2 escorted the resident back into the group home and Resident #1 retreated to her bedroom. Reportedly, Resident #1 again began to say she was leaving the and Staff #1 blocked the door way to her bedroom and Resident #1 is unable to get out of the bedroom. Resident #1 became upset and threw a radio at Staff #1. Staff #1 called for assistance from other staff on duty. Resident #1's behavior escalated and she began to throw, bang and knock over furniture in her bedroom. All three direct care staff attempt to intervene without success. Staff #2 called 911 and notified the House Manager. According to the report the D.C. Metropolitan Police arrived at the group home at approximately 8:45 p.m. It was decided that Staff #2 would escort Resident #1 to the CPEP for emergency evaluation and treatment.	1422			

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I 422	Continued From page 4 Review of Resident #1's Behavior Support Plan dated May 27, 2009 revealed that a progression of interventions are to occur as follows: 1. Tell her to "STOP!" 2. Verbally redirection is provided. 3. Touch control redirection is provided to guide and prompt her to engage in a behavior. 4. A Safety zone is implemented in order to separate her during intense or deteriorating interpersonal or dangerous situation. 5. During an emergency, request for assistance and implementation of the agency's policies and procedures. According to the incident report Staff #1 blocked Resident #1 in her bedroom and the resident's behavior escalated. Reportedly, staff were trained on the implementation of Resident #1's behavior support plan and interventions on July 31, 2009. The BSP noted specifically in the Safety Zone intervention the following: "A safety zone is not seclusion. [The Resident] should never be locked in any room or denied egress." It should be noted that Resident #1's behavior did not escalate until Staff #1 blocked her bedroom doorway.	I 422		