

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

PRINTED: 10/29/2010  
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  10/19/2010
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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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W 000 INITIAL COMMENTS W 000

A recertification survey was conducted from 10/18/2010 through 10/19/2010. A sample of two clients was selected from a population of three women with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process.

The findings of the survey were based on observations and interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS W 124

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.

In the future, all medication changes for Client #2 will be discussed with the medical guardian before the start date of any changes in medication. QMRP will obtain a signed consent form and will submit it to the Human Rights Committee for review.

10/28/10

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION ADMINISTRATION  
825 NORTH CAPITOL ST., N.E., 2ND FLOOR  
WASHINGTON, D.C. 20002  
11-8-10

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to establish a system to ensure that each client or his/her authorized surrogate healthcare decision-maker, was informed of the client's medical condition and proposed change in treatment plans, for one of the two clients in the sample. (Client #2)

The finding includes:

On 10/18/2010, at approximately 10:10 a.m., interview with the qualified mental retardation professional (QMRP) revealed that Client #2 was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Courtney A. Keen Program Director* TITLE  
11/8/10 (X6) DATE

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 124	<p>Continued From page 1</p> <p>receiving psychotropic medications for treatment of a psychiatric condition (psychosis) and for behavior management. The QMRP further indicated that the client had a court-appointed medical guardian who had provided written consent for the use of the medications.</p> <p>On 10/18/2010, at approximately 1:15 p.m., review of Client #2's Individual Support Plan (ISP) dated 5/28/2010, revealed that her diagnoses included insulin-dependent diabetes, moderate mental retardation, schizophrenia and post traumatic stress disorder. The ISP also confirmed that Client #2 had a court-appointed healthcare decision-maker due to her impaired ability to process information.</p> <p>On 10/18/2010, beginning at 11:30 a.m., review of the client's records revealed that her medical guardian had signed a consent form on 8/1/2010 that reflected Risperdal 2 mg and Trazodone HCL 100 mg every evening. At 11:42 p.m., review of her Psychiatry Medical Service forms, Physician's Orders and Medication Administration Records from July 2010 - October 2010 revealed a graduated reduction and discontinuation of her Risperdal and a 75% reduction in her Trazodone HCL. There was no evidence in Client #2's record that her guardian was consulted about her mental status before the medical team began titrating the Risperdal and Trazodone.</p> <p>On 10/19/2010, beginning at approximately 1:05 p.m., follow-up interview with the QMRP and the facility's RN revealed that the primary care physician had ordered the reduction in medications. The QMRP looked at the consent form that the guardian signed on 9/1/2010 and confirmed that it reflected Risperdal 2 mg and</p>	W 124		

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W 124	<p>Continued From page 2</p> <p>Trazodone HCL 100 mg every evening. The QMRP and RN indicated that the medications were reduced to address reports of lethargy and excessive sleeping at the day program. The QMRP further stated that the psychiatrist had expressed interest in lowering "all" of her psychotropic medications. She then acknowledged that to date, the facility had not informed the guardian of Client #2's recent mental status or discussed with her the potential risks and benefits associated with changing the client's psychotropic medication regimen.</p> <p>This is a repeat deficiency:</p> <p>_____</p> <p>Previously, the Federal Deficiency Report dated 11/19/2009 included the following:</p> <p>"... Observation of the evening medication pass on November 16, 2009 revealed that Client #2 received Depakote 1000 mg, Thorazine 400 mg, Trazodone 100 mg and Abilify 30 mg. During the entrance conference, the QMRP and HM had indicated that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The client had a court appointed guardian to assist her in making healthcare decisions. The client's medical records were reviewed on November 18, 2009 beginning at 11:38 a.m.</p> <p>Her physician's orders (POs) indicated that Trazodone 50 mg was first ordered on August 3, 2009, with the first dose documented on her Medication Administration Record (MAR) as administered the next evening (August 4, 2009). The Trazodone was then doubled to 100 mg</p>	W 124		

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**W 124** Continued From page 3  
daily, effective October 16, 2009. Client #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.

**W 124**

On November 18, 2009 at 2:53 p.m., the most recent consent form in Client #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and Depakote..."

**W 126** 483.420(a)(4) PROTECTION OF CLIENTS RIGHTS

**W 126**

The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to teach clients to manage their own financial affairs, for one of the two clients in the sample. (Client #2)

The finding includes:

During observations at Client #2's day program on 10/18/2010, at approximately 1:20 p.m.,

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W 126	<p>Continued From page 4</p> <p>review of the client's day program Individual Program Plan (IPP), dated 5/31/2010, revealed that she had completed her "computing coins for the given value" program at 100% independence during the previous year and the objective had been discontinued. Continued review of the current IPP revealed no indication that a new money management training objective had been established. At approximately 1:30 p.m., interview with the day program case manager confirmed that Client #2 did not have a current money management training program. The client reportedly knew how to use money, including asking for change and counting the change. She further indicated that the client displayed significant, disruptive "behaviors" if staff did not allow her to buy 'junk foods' that did not comply with her prescribed diet (1800 calorie diabetic ADA, low fat, low cholesterol and low sodium).</p> <p>On 10/18/2010, at 3:37 p.m., review of an evaluation of Client #2's money management skills, dated 8/27/2010, revealed that she was independent in recognizing coins, counting money, and making purchases. Continued review of the evaluation, however, revealed that for "manages money," she required "maximum assistance."</p> <p>On 10/18/2010, at approximately 4:20 p.m., interview with the qualified mental retardation professional (QMRP) revealed information similar to that shared by the day program case manager. The QMRP stated Client #2 was "very good with money." She confirmed that the client did not have a money management training program. The QMRP further indicated that the client did not handle her personal funds (petty cash or banking) due to her impulsivity, poor choice making and behavioral outbursts if she could not purchase</p>	W 126	<p>QMRP will develop a Money Management Program for Client #2 that will be appropriate to meet her needs. The program will be coordinated with the day program. The QMRP will implement a financial plan that will allow Client #2 to make weekly purchases.</p>
			11/22/10

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W 126 Continued From page 5  
'junk food.'

There was no evidence that the facility developed and implemented a money management training program appropriate to meet Client #2's needs.

It should be noted that Client #2's annual plan, dated 5/31/2010, indicated that her day program was tasked with developing a money management training program. There was no evidence, however, that the facility addressed this need in the 5 months that passed since the interdisciplinary team met on 5/31/2010.

W 126

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 observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination of training programs and services to promote the health and safety of two of the two sampled clients. [Clients #1 and #2]

The findings include:

1. Interview with staff at Client #1 's day program on 10/19/2010 at 11:20 a.m. revealed she was refusing to take part in her exercise program which entailed walking for short distances and being monitored by a pedometer. Further interview with the day program 's case manager on the same day and time revealed he had emailed several documents to the home

W 159

1. The QMRP will schedule a conference with Client #1's day program to coordinate services for her exercise program. The QMRP will also request ongoing monthly/quarterly progress notes.

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W 159 Continued From page 6

W 159

regarding Client #1 ' s refusals and lack of progress with the walking program. Review of Client #1 ' s IPP data for her walking program on the same day at approximately 11:50 a.m. confirmed Client #1 was refusing to take part in her walking program for the month of 10/2010 and there was no data on record between 8/6/2010 (date of ISP) and 10/1/2010. Further interview with the case manager and the classroom instructor revealed the pedometer was only purchased within the past two weeks.

Interview with the facility ' s qualified mental retardation professional (QMRP) on 10/19/2010 at approximately 3:30 p.m. revealed she was not aware Client #1 was failing to show progress and was refusing to take part in her walking program at the day program. The QMRP indicated Client #1 successfully engages in her walking program at the home and does so with consistent encouragement, so she could not understand why she was refusing at the day program. Further interview with the QMRP revealed she had not received any information from the day program regarding Client #1 ' s lack of progress.

Record review on 10/19/2010 at approximately 3:35 p.m. revealed Client #2 ' s written day program objective reflected: " Given verbal prompts from staff, [Client #1] will keep count of her steps daily using a pedometer 25% of the opportunities provided for 3 consecutive months (daily). " Further record review on the same day at approximately 3:45 p.m. revealed Client #1 ' s 8/2/2010 Nutritional assessment documented she weighted 159 lbs. The assessment goes on to further identify that Client #1's ideal body weight range (IBW) was 115 - 129 lbs.

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W 159 Continued From page 7

W 159

Additional interview with the facility's QMRP on 10/19/2010 at approximately 3:40 p.m. confirmed Client #1 needs her exercise programs to help her lose weight. The QMRP also confirmed there was a communication breakdown between the day program and the home with regards to Client #1's failure to take part in her walking program. The QMRP also indicated she meet with the day program to ascertain why it took the day program over two months to secure the pedometer and implement the walking program as identified on the 8/6/2010 ISP.

The facility's QMRP failed to ensure an effective coordination of Client #1's exercise programs with outside services as recommended by her nutritionist.

2. The QMRP failed to ensure that Client #2 received training on money management, as deemed appropriate by the interdisciplinary team. [See W128]

2. Cross reference W128 11/22/10

3. The QMRP failed to ensure that staff implemented Client #2's training program to "prepare her evening snack 3 days a week with verbal prompts..." as prescribed. [See W249]

3. Cross reference W249 11/19/10

4. The QMRP failed to ensure accurate data collection for Client #2's Individual Program Plan (IPP) objective to "prepare her evening snack 3 days a week with verbal prompts..." [See W252]

4. Cross reference W252 11/19/10

5. There was no evidence that the QMRP ensured that Client #2's interdisciplinary team, to include her medical guardian, were aware of the dentist's recommendation, 9/22/2009, for a "3-units bridge." The dentist had indicated the "procedure needs to be done under deep

5. Cross reference W356 11/23/10

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W 159 Continued From page 8  
conscious sedation. She is apprehensive..."  
Review of the client's annual plan, followed by interview with the QMRP and RN failed to show evidence that this subject had been addressed. [See W356]

W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN : W 247  
The individual program plan must include opportunities for client choice and self-management.

This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that each client was provided opportunities to make a choice during snack time, for three of the three clients residing in the facility. (Clients #1, #2, and #3)

Staff will receive additional training on preparing daily individual snacks. Staff will be monitored by QMRP to encourage offering choices for snacks to each individual.

11/19/10

The finding includes:

Observation on 10/18/2010, at approximately 3:50 p.m., revealed a direct support staff person taking granola bars from the kitchen out to the front porch, where the three clients were gathered. The staff handed a granola bar to each individual. The next day, at approximately 3:27 p.m., staff was observed pouring unsweetened apple sauce from the original cans into three small bowls for individual servings. On both days, staff prepared the snack items without offering clients a choice between snack items of similar nutritional value. [Note: All three clients were prescribed 1800 calorie, low fat diets.]

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION : W 249  
As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active

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(X4) ID PREFIX TAG  <b>W 249</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>W 249</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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.

Client #2 will be given the opportunity to prepare her evening snack 3 days a week using verbal prompts. QMRP will monitor staff for implementation of this objective.

11/19/10

This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement training programs as recommended by the interdisciplinary team, for one of the two sampled clients. [Client #2]

The finding includes:

On 10/18/2010, at 4:34 p.m., the qualified mental retardation professional (QMRP) stated that Client #2's Individual Program Plan (IPP), dated 5/31/2010, included a training program in which she would prepare her own snack. She indicated that this was a means to keep the client actively engaged and to instruct her on portion control. The QMRP offered the example of the client learning to take 2 graham crackers instead of the entire box of crackers. Review of the IPP confirmed the program to "prepare her evening snack 3 days a week with verbal prompts..."

However, on 10/18/2010, at approximately 3:50 p.m., a direct support staff person was observed taking granola bars from the kitchen out to the front porch, where the clients were gathered. The staff handed a granola bar to Client #2 and a bar to each of her two housemates. The next day, at approximately 3:27 p.m., staff was observed pouring unsweetened apple sauce from the original cans into small bowls for individual

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servings. Client #2 and a peer stood nearby, watching the staff. On both days, staff prepared the snack items rather than involve Client #2, to ensure implementation of her training program.

W 252 483.440(e)(1) PROGRAM DOCUMENTATION

W 249  
  
  
  
  
  
  
  
  
  
  
  
W 252

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

Staff will receive additional training on data collection for Client #2's training program in snack preparation. QMRP will monitor and review documentation weekly.

11/19/10

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate documentation of Individual Program Plan (IPP) objectives, for one of the two clients in the sample. (Client #2)

The findings include:

[Cross Reference W249]

Observation on 10/18/2010, at approximately 3:50 p.m., revealed a direct support staff person was observed taking granola bars from the kitchen out to the front porch, where the clients were gathered. At approximately 4:02 p.m., the staff person confirmed that she had given a granola bar to Client #2 and a bar to each of her two housemates.

On 10/19/2010, at approximately 3:45 p.m., review of Client #2's program to "prepare her evening snack 3 days a week with verbal prompts..." revealed that on 10/18/2010, staff documented that Client #2 had "gathered appropriate items for the snack" and "prepared

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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  10/19/2010
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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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W 252 Continued From page 11  
the snack" with "V1, minimum verbal prompts." Staff, however, had been observed performing those tasks on that afternoon.

W 252

W 356 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT

W 356

The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

QMRP will schedule a conference with the interdisciplinary team to discuss dental consultation for Client #2. The team will be requested to review recommendations from consultation dated 9/22/2009.

11/23/10

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the two clients in the sample. (Client #2)

The finding includes:

Review of Client #2's medical record on 10/19/2010, at 12:37 p.m., revealed a dental consultation dated 9/22/2009. The dentist noted that the client "needs a 3-units bridge. Procedure needs to be done under deep conscious sedation. She is apprehensive..." Further review revealed no evidence that the client's interdisciplinary team, to include her medical guardian, had discussed the recommendation and determined whether or not to proceed with the "3-units bridge."

On 10/19/2010, beginning at 1:27 p.m., a joint interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) in the facility confirmed that to their knowledge, there had been no team discussions or decisions made regarding the dentist's recommendation.

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1 000 INITIAL COMMENTS 1 000

A licensure survey was conducted from 10/18/2010 through 10/19/2010. A sample of two residents was selected from a population of three women with various degrees of intellectual and/or developmental disabilities.

The findings of the survey were based on observations and interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.

1 090 3504.1 HOUSEKEEPING 1 090

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by: Based on observation, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive and sanitary manner,

The findings include:

During the environmental inspection on 4/21/2010 at 5:20 p.m. the following deficiencies were observed:

1. The light fixture in the basement was missing its protective cover (glass lamp bowl).
2. Several light bulbs in the chandelier in the dining room were burnt out and inoperable. The

1. Light fixture in the basement was repaired by replacing protective cover over the light. 10/19/10

2. Light bulbs were replaced in the chandelier in the dining room. 10/19/10

Health Regulation Administration  
*Christine C. Reese* Program Director TITLE  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE

(X6) DATE

11/8/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2010</b>
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I 090	Continued From page 1  same was observed in bathroom #2 on the second floor.	I 090	
I 095	3504.6 HOUSEKEEPING  Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.  This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all caustic agents were kept in a locked cabinet and out of the reach of its residents for three of three residents residing in the facility. [Residents #1, #2 and #3]  The finding includes:  Observation on 10/18/2010 at approximately 12:45 p.m. revealed cleaning agents (scouring powder and dishwashing detergent) were being stored in an unlocked cabinet below the kitchen sink. Interview with the facility's qualified mental retardation professional (QMRP) confirmed that the cleaning agents were in the cabinet below the kitchen sink and agreed to have them removed immediately and locked away. Further interview on the same day at approximately 12:55 p.m. confirmed there was a cabinet in the basement to house all poisonous and caustic agents. The QMRP indicated she would ensure staff were aware of this requirement and would have them lock all cleaning agents away after use.	I 095	The staff will be trained on putting away cleaning agents in a locked safety area when they are not being used. QMRP will monitor daily for compliance. <span style="float: right; border: 1px solid black; padding: 2px;">10/19/10</span>
I 096	3504.7 HOUSEKEEPING  No poisonous or hazardous agent shall be stored	I 096	

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1 096 Continued From page 2  
In a food preparation, storage or serving area.

This Statute is not met as evidenced by:  
Based on observation and staff interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure the kitchen was remained free of all caustic agents to ensure the health and safety of three of three residents residing in the facility. [Residents #1, #2, and #3]

The finding includes:

Observation on 10/18/2010, at approximately 12:45 p.m., revealed cleaning agents (scouring powder and dishwashing detergent) were being stored in the cabinet below the kitchen sink. Interview with the facility's qualified mental retardation professional (QMRP) confirmed that the cleaning agents were in the cabinet below the kitchen sink and agreed to have them removed immediately.

Cross reference 1095 10/19/10

1 180 3508.1 ADMINISTRATIVE SUPPORT

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

This Statute is not met as evidenced by:  
Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure qualified mental retardation professional (QMRP) services to meet residents' needs, for two of the two residents in the sample. [Residents #1 and #2]

The findings include:

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I 180	<p>Continued From page 3</p> <p>1. Interview with staff at Resident #1 ' s day program on 10/19/2010 at 11:20 a.m. revealed she was refusing to take part in her exercise program which entailed walking for short distances and being monitored by a pedometer. Further interview with the day program ' s case manager on the same day and time revealed he had emailed several documents to the home regarding Resident #1 ' s refusals and lack of progress with the walking program. Review of Resident #1 ' s IPP data for her walking program on the same day at approximately 11:50 a.m. confirmed Resident #1 was refusing to take part in her walking program for the month of 10/2010 and there was no data on record between 8/6/2010 (date of ISP) and 10/1/2010. Further interview with the case manager and the classroom instructor revealed the pedometer was only purchased within the past two weeks.</p> <p>Interview with the facility ' s qualified mental retardation professional (QMRP) on 10/19/2010 at approximately 3:30 p.m. revealed she was not aware Resident #1 was failing to show progress and was refusing to take part in her walking program at the day program. The QMRP indicated Resident #1 successfully engages in her walking program at the home and does so with consistent encouragement, so she could not understand why she was refusing at the day program. Further interview with the QMRP revealed she had not received any information from the day program regarding Resident #1 ' s lack of progress.</p> <p>Record review on 10/19/2010 at approximately 3:35 p.m. revealed Resident #2 ' s written day program objective reflected: " Given verbal prompts from staff, [Resident #1] will keep count of her steps daily using a pedometer 25% of the</p>	I 180	<p>Cross reference W159 QMRP will coordinate services with the day program to assist with Client #1 when she refuses to take part in day program activities.</p>	11/23/10
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I 180	<p>Continued From page 4</p> <p>opportunities provided for 3 consecutive months (daily). " Further record review on the same day at approximately 3:45 p.m. revealed Resident #1 ' s 8/2/2010 Nutritional assessment documented she weighted 159 lbs. The assessment goes on to further identify that Resident #1 ' Ideal body weight (IBW) was 115 - 129 lbs.</p> <p>Additional interview with the facility ' s QMRP on 10/19/2010 at approximately 3:40 p.m. confirmed Resident #1 needs her exercise programs to help her lose weight. The QMRP also confirmed there was a communication breakdown between the day program and the home with regards to Resident #1 ' s failure to take part in her walking program. The QMRP also indicated she meet with the day program to ascertain why it took the day program over two months to secure the pedometer and implement the walking program as identified on the 8/6/2010 ISP.</p> <p>The facility ' s QMRP failed to ensure an effective coordination of Resident #1 ' s exercise programs with outside services as recommended by her nutritionist.</p> <p>2. The QMRP failed to ensure the development and implementation of an appropriate money management training program for Resident #2. [See Federal Deficiency Report - Citation W126]</p> <p>3. The QMRP failed to ensure that staff implemented Resident #2's training program to "prepare her evening snack 3 days a week with verbal prompts..." as prescribed. [See I422]</p> <p>4. The QMRP failed to ensure accurate data collection for Resident #2's Individual Program Plan (IPP) objective to "prepare her evening snack 3 days a week with verbal prompts..." [See</p>	I 180	<p>2. Cross reference W126</p> <p>3. Cross reference W247</p> <p>4. Cross reference W252</p>
			11/22/10
			11/19/10
			11/19/10

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I 180	Continued From page 5 Federal Deficiency Report - Citation W252]	I 180	
I 203	3509.3 PERSONNEL POLICIES  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure the GHMRP's supervisory staff afforded each employee the opportunity to discuss their job descriptions at least annually as required by this section. [Staffs #2, #4 and #5]  The finding includes:  Record review and interview with the GHMRP's qualified mental retardation professional on 10/18/2010, at approximately 10:30 a.m., revealed there was no written evidence that the facility's supervisor afforded S2, S4 and S5 the opportunity to discuss and review their current job description over the past year.	I 203	Job Descriptions will be reviewed with S2, S4 and S5 annually  11/15/10
I 222	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all staff received training on residents' individualized behavior support plans and specialized diets/menus, for 2 of the 8 direct support staff in the facility.	I 222	

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I 222	Continued From page 6  The findings include:  On 10/18/10, at approximately 8:05 p.m., the two overnight staff (12:00 a.m. - 8:00 a.m. shift) staff were interviewed as they prepared to leave the GHMRP. They both stated that they had received general training on principles of behavior management as well as nutrition and menus. They further stated that they had not received resident specific training regarding Resident #1's or Resident #2's behavior support plans (BSPs), 8/4/2010 and 5/25/2010, respectively, or their specialized diets.  Staff in-service training records were reviewed on 10/19/10, beginning at 1:57 p.m. The facility documented having provided in-service training on 1/14/20; however, review of the signature sheets revealed that neither staff had attended that training. There was no documented evidence of more recent training on the two residents' BSPs or specialized diets, within the past 9 months. It should be noted that the qualified mental retardation professional indicated that one of the two overnight staff had been hired approximately 90 days prior to the survey.	I 222	Staff will receive additional training on two individual's BSP's and specialized diets. All new hired staff will immediately receive training on BSP's and specialized diets. QMRP will document all training.	11/15/10	
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: Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to provide training in accordance with Individual Support Plans, for two of the two sampled residents. (Residents #1 and	I 422			



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I 500	<p>Continued From page 12</p> <p>The Trazodone was then doubled to 100 mg daily, effective October 16, 2009. Resident #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.</p> <p>On November 18, 2009 at 2:53 p.m., the most recent consent form in Resident #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and Depakote..."</p>	I 500	

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I 422	Continued From page 8  interview with the day program case manager on the same day and time revealed he had emailed several documents to the home regarding Resident #1's refusal and lack of progress. Review of Resident #1's IPP data for her walking program on the same day at approximately 11:50 a.m. confirmed Resident #1 was refusing to take part in her walking program and her data reflected a failure to progress.  Interview with the QMRP on 10/19/2010, at approximately 3:30 p.m. revealed she was not aware Resident #1 was failing to show progress with her walking program at the day program. The QMRP indicated Resident #1 successfully engages in her walking program at the home and complies with consistent encouragement. Further interview revealed she had not received any information from the day program regarding Resident #1's lack of progress  Record review on 10/19/2010, at approximately 3:35 p.m. revealed Resident #1's written day program objective reflected: "Given verbal prompts from staff, [Resident #1] will keep count of her steps daily using a pedometer 25% of the opportunities provided for 3 consecutive months (daily)." Further record review on the same day at approximately 3:45 p.m. revealed Resident #1's 8/2/2010 Nutritional assessment presented her ideal body weight (IBW) ranged from 115 - 129 lbs, but she was assessed to weigh 156 lbs. Additional review of the monthly weights between the months of 1/2010 and 6/2010 revealed she weighed an average of 159 lbs.  Additional interview with the facility's QMRP confirmed Resident #1 needs her exercise program to help her lose weight and also confirmed there was a communication	I 422		

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W 249 Continued From page 9  
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.

W 249

This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement training programs as recommended by the interdisciplinary team, for one of the two sampled clients. [Client #2]

Client #2 will be given the opportunity to prepare her evening snack 3 days a week using verbal prompts. QMRP will monitor staff for implementation of this objective.

11/19/10

The finding includes:

On 10/18/2010, at 4:34 p.m., the qualified mental retardation professional (QMRP) stated that Client #2's Individual Program Plan (IPP), dated 5/31/2010, included a training program in which she would prepare her own snack. She indicated that this was a means to keep the client actively engaged and to instruct her on portion control. The QMRP offered the example of the client learning to take 2 graham crackers instead of the entire box of crackers. Review of the IPP confirmed the program to "prepare her evening snack 3 days a week with verbal prompts..."

Staff will receive training on each individual's IPP goals and on how each objective will be documented.

11/17/10

However, on 10/18/2010, at approximately 3:50 p.m., a direct support staff person was observed taking granola bars from the kitchen out to the front porch, where the clients were gathered. The staff handed a granola bar to Client #2 and a bar to each of her two housemates. The next day, at approximately 3:27 p.m., staff was observed pouring unsweetened apple sauce from the original cans into small bowls for individual

*Constantine A. Reese Program Director 11/10/10*

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W 249	Continued From page 10 servings. Client #2 and a peer stood nearby, watching the staff. On both days, staff prepared the snack items rather than involve Client #2, to ensure implementation of her training program.	W 249			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate documentation of Individual Program Plan (IPP) objectives, for one of the two clients in the sample. (Client #2)  The findings include:  [Cross Reference W249]  Observation on 10/18/2010, at approximately 3:50 p.m., revealed a direct support staff person was observed taking granola bars from the kitchen out to the front porch, where the clients were gathered. At approximately 4:02 p.m., the staff person confirmed that she had given a granola bar to Client #2 and a bar to each of her two housemates.  On 10/19/2010, at approximately 3:45 p.m., review of Client #2's program to "prepare her evening snack 3 days a week with verbal prompts..." revealed that on 10/18/2010, staff documented that Client #2 had "gathered appropriate items for the snack" and "prepared	W 252	Staff will receive additional training on data collection for Client #2's training program in snack preparation. QMRP will develop and implement a weekly monitoring system that will outline objectives and activities to be completed for a designated time period. QMRP will observe activities 2 x's weekly and evaluate progress using a goal observation form. QMRP will have weekly meeting with staff to ensure adequate documentation for each objective.	11/19/10	

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

PRINTED: 10/29/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4314 9TH STREET NW WASHINGTON, DC 20011</b>
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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 252 Continued From page 11  
the snack" with "V1, minimum verbal prompts." Staff, however, had been observed performing those tasks on that afternoon.

W 252

W 356 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT

W 356

The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the two clients in the sample. (Client #2)

The finding includes:

Review of Client #2's medical record on 10/19/2010, at 12:37 p.m., revealed a dental consultation dated 9/22/2009. The dentist noted that the client "needs a 3-units bridge. Procedure needs to be done under deep conscious sedation. She is apprehensive..." Further review revealed no evidence that the client's interdisciplinary team, to include her medical guardian, had discussed the recommendation and determined whether or not to proceed with the "3-units bridge."

On 10/19/2010, beginning at 1:27 p.m., a joint interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) in the facility confirmed that to their knowledge, there had been no team discussions or decisions made regarding the dentist's recommendation.

QMRP will schedule a conference with the interdisciplinary team to discuss dental consultation for Client #2. The team will be requested to review recommendations from consultation dated 9/22/2009. Client #2 also has a dental appointment scheduled in January 2011, and is currently waiting approval from her current dentist for dental scaling.

11/23/10

PRINTED: 10/29/2010  
FORM APPROVED

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  10/19/2010
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) COMPLETE DATE	
I 500	Continued From page 12  The Trazodone was then doubled to 100 mg daily, effective October 16, 2009. Resident #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.  On November 18, 2009 at 2:53 p.m., the most recent consent form in Resident #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and Depakote..."	I 500			