

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

PRINTED: 10/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/13/2012
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NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE WASHINGTON, DC 20019
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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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*Received  
10/31/12*

W 000 INITIAL COMMENTS

W 000

A-recertification survey was conducted from September 11, 2012 through September 13, 2012. A sample of two clients was selected from a population of three men with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.

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

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

W 111 483.410(c)(1) CLIENT RECORDS

W 111

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients' records consistently reflected the findings, treatments rendered and recommendations made by health care specialists, for one of the two clients in the sample. (Client #1)

The findings include:

1. The facility failed to maintain Client #1's records to reflect podiatry services, as follows:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Catherine Moore, Director of Residential Services* 10/31/12

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 111	<p>Continued From page 1</p> <p>[Cross-refer to W322.1] On September 11, 2012, at 10:01 a.m., the registered nurse (RN), Staff #6 and the qualified intellectual disabilities professional (QIDP), Staff #4, were interviewed about an incident involving Client #1. According to the incident report, dated August 22, 2012, the client sustained an injury to a toe on his right foot and was subsequently taken to a local emergency room (ER). The ER discharge summary reflected the doctors found he had long toe nails which might have contributed to the injury. According to the RN and the QIDP, the client had received podiatry services six months earlier, in March 2012.</p> <p>On September 12, 2012, at 10:57 a.m., review of Client #1's podiatry records revealed a consultation form dated November 9, 2011. The podiatrist at that time (C4) documented having "reduced all nails" and would return "February 2012." A primary care physician (PCP) note dated March 14, 2012 indicated the client returned to the podiatrist on March 7, 2012. The PCP note did not, however, reflect the treatments and/or recommendations made by the podiatrist on March 7, 2012. A QIDP monthly summary report indicated the client "was seen by the podiatrist on March 7, 2012; follow-up in three months." The QIDP summary also did not reflect the podiatrist's treatments and/or recommendations. The client's record did not, however, contain a consultation form to verify that the podiatrist had assessed the client and provided treatment.</p> <p>When interviewed again on September 13, 2012, at 1:24 p.m., the RN stated that she had seen the March 7, 2012 consultation form in the past. She</p>	W 111	<p>W111</p> <p>1. Client #1 was seen by his podiatrist on...10-3-12 He received further treatment on his toe. The podiatrist suggested that he receive a soaking treatment daily for 7 days and return in a week for reevaluation. This treatment was done and he returned to visit podiatry again on... 10-10-12</p> <p>At that point the podiatrist indicated the problem was resolved (See: attached consultations)</p> <p>The RN will track all medical consultation needs supported by the Nursing Office and will meet monthly with the QIDP to review the status of all upcoming consultations. The RN will report monthly to the DON the status of upcoming medical consultations...10-1-12</p> <p>MTS is seeking the services of a podiatrist that will service the individuals via home visits quarterly as opposed to at their offices. A candidate has been identified...10-17-12</p>

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W 111 Continued From page 2  
further stated that she had looked through Client #1's records that morning and acknowledged that the consultation form was not in the record.

2. The facility failed to maintain Client #1's medical records to reflect the results of his serum laboratory tests, as follows:

The evening medication administration was observed on September 11, 2012. At 6:31 p.m., Client #1 was administered Simvastatin 5 mg. The medication nurse (Staff #5) indicated that the client received this medication to control elevated serum cholesterol.

On September 12, 2012, at approximately 3:30 p.m., review of Client #1's laboratory study reports revealed documented labs drawn on August 8, 2011, November 30, 2011 and August 23, 2012. At 4:39 p.m., review of QIDP monthly summary reports for May and June 2012 revealed Client #1 had labs drawn on April 3, 2012. Reports showing the results of those labs, however, were not observed in the client's medical records.

On September 13, 2012, at approximately 2:00 p.m., the QIDP examined Client #1's records and acknowledged that the April 3, 2012 lab reports were not in the record.

3. The facility failed to maintain Client #1's medical records to reflect the results of dental services, as follows:

On September 12, 2012, at approximately 11:35 a.m., review of Client #1's dental records revealed that he had a tooth extracted on January

W 111

2. MTS did follow up with the lab and recovered the April 3, 2012 lab work for client #1...10-17-12 Client #1 has since had lab work done in August 2012 that demonstrated no major concerns...10-1-12  
The RN will track all medical consultations including lab work to ensure that results are routinely obtained in a timely manner. The DON will follow up with the nursing office staff to ensure that they provide effective support in the process...10-30-12
3. Client #1 did have the tooth removed in the January visit. Confirmation has been obtained (See: attachment)...10-1-12

Client #1 was scheduled to see the dentist on...6-25-12 but was not seen.

He has been rescheduled for...10-23-12

The RN and QIDP will meet monthly to systematically review the status of all needed medical follow up in an individualized manner...11-1-12

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W 111 Continued From page 3  
17, 2012. The dentist also wrote the client's "next visit June 18, 2012." At 4:45 p.m., review of a nursing quarterly assessment, dated June 30, 2012, revealed the RN (Staff #6) wrote "last dental exam...December 20, 2011." Continued review of the medical chart failed to show evidence that the client had returned to the dentist in June.

W 111

On September 13, 2012, at 1:10 p.m., interview with the RN revealed that she had not previously seen the dental consultation report form dated January 17, 2012. She could not say whether the client had been to the dentist on June 18, 2012. At 1:55 p.m., concurrent interviews with a direct support staff (Staff #2), the house manager (Staff #3) and the QIDP revealed that Staff #2 had driven Client #1 to a dental appointment in June 2012. Staff #2 reportedly faxed a copy of the consultation sheet to the designated nurse in the nursing office (Staff #7) and then filed the original form in "an appointments book." They were unable to locate the form during the interview. At approximately 2:03 p.m., the QIDP said he would try to secure a copy of the June 18, 2012 dental consultation form. However, no additional information was shared before the survey ended that evening at 6:00 p.m.

W 322 483.460(a)(3) PHYSICIAN SERVICES

W 322

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure preventive and

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W 322 Continued From page 4  
general medical services were provided, for two of the two clients in the sample. (Clients #1 and #2)

The findings include:

1. The facility's medical team failed to ensure that Client #1 received timely podiatry services, as follows:

On September 11, 2012, at 10:01 a.m., the registered nurse (RN), Staff #6 and the qualified intellectual disabilities professional (QIDP), Staff #4, were interviewed about an incident involving Client #1. According to the incident report, dated August 22, 2012, the client sustained an injury to a toe on his right foot and was subsequently taken to a local emergency room (ER). The ER discharge summary reflected the doctors found he had long toe nails which might have contributed to the injury. According to the RN and the QIDP, the client had received podiatry services six months earlier, in March 2012. Continued discussion with Staff #4 and Staff #6 revealed that the client was supposed to receive podiatry services every three months.

On September 12, 2012, at 10:46 a.m., review of Client #1's medical records revealed that the client's most recent documented podiatry visit was conducted on November 9, 2011, ten months earlier. Although the QIDP stated that Client #1 had been seen by the podiatrist on March 7, 2012, this could not be verified through record review. During the Exit Conference held September 13, 2012, Staff #4 and Staff #6 acknowledged that at least six months had passed since the client had received podiatry

W 322

W322

1. Client #1 was seen by his podiatrist on...10-3-12 He received further treatment on his toe. The podiatrist suggested that he receive a soaking treatment daily for 7 days and return in a week for reevaluation. This treatment was done and he returned to visit podiatry again on... 10-10-12  
At that point the podiatrist indicated the problem was resolved (See: attached consultations)

The RN will track all medical consultation needs supported by the Nursing Office and will meet monthly with the QIDP to review the status of all upcoming consultations. The RN will report monthly to the DON the status of upcoming medical consultations...10-1-12

MTS is seeking the services of a podiatrist that will service the individuals via home visits quarterly as opposed to at their offices. A candidate has been identified...10-17-12

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W 322 Continued From page 5  
care.

W 322

2. The facility's medical team failed to ensure Client #1 received timely orthopedic services, as follows:

On September 11, 2012, at 4:34 p.m., the RN (Staff #6) stated that Client #1 was due to receive "new molded shoes." Prior to that, the client's specialized shoes had not been noticeably different from ordinary shoes. The RN explained that the client had inserts to support the arches.

On September 12, 2012, at 11:08 a.m., review of Client #1's orthopedic consultation sheet dated May 11, 2011 revealed that he "was dispensed with ... walking shoes and accommodative orthotics to support patient's feet... Return appointment needed April 2012." Continued review of the client's medical and QIDP records failed to show evidence that he had returned to the orthopedic clinic as recommended.

The RN and the QIDP were asked on September 13, 2012, at 2:33 p.m. whether Client #1 had returned to the orthopedic specialist since May 11, 2011. No additional information was provided before the survey ended that day at 6:00 p.m.

3. The facility's medical team failed to ensure that Client #2 received timely urology services, as follows:

While verifying the evening medication administration on September 11, 2012, at 7:00 p.m., it was observed that Client #2 received Detrol LA U-D 4 mg every morning. This was his only oral medication prescribed.

2. As indicated, Client #1 did not return to see the orthopedic specialist in April 2012. However, he did return in October 2012...10-12-12  
He was fitted for a new pair of shoes and they were ordered at that time...10-17-12  
Client #1 has a pair of orthopedic shoes that are in good shape for everyday wear but will benefit from having a second pair...10-17-12

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W 322	Continued From page 6  On September 13, 2012, at 11:10 a.m., review of Client #2's urology records revealed a consultation form dated September 30, 2011. The urologist documented the client was "Detrol compliant...no voiced complaints...follow-up in 6 months." At 11:15 a.m., review of the client's POS (from December 2011 onward) and his Annual Medical Evaluation, dated December 15, 2011, revealed no orders or instructions from the PCP regarding the client's urology needs. Continued review of Client #2's medical and QIDP records failed to show evidence that he had returned to the urologist in the ensuing 11 1/2 months.  On September 13, 2012, at 5:20 p.m., the RN (Staff #6) examined Client #2's records, spoke with the house manager (Staff #3) and called the designated nurse in the nursing office (Staff #7) who was responsible for scheduling medical appointments and follow-up. At 5:38 p.m., the RN stated that she had no new information, and the facility would schedule a follow-up appointment with the urologist.	W 322	3. Urology follow up has been scheduled for Client #2 and for...10-29-12 The RN and QIDP will track medical follow up in their monthly team meetings ensuring that all needed appointments are scheduled and implemented in a timely manner...11-1-12  It should be noted that the RN's hours dedicated to this home weekly have been increased and the QIDP, formally a consultant, is now full time...10-1-12
W 331	483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with each client's needs, for one of the two clients in the sample. (Client #1)  The finding includes:	W 331	

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W 331 Continued From page 7

W 331

The facility's nursing staff failed to ensure Client #1 received medication as ordered by the psychiatrist, as follows:

Observation on September 11, 2012, at 6:30 p.m., revealed Client #1 being administered Quetiapine Fumarate (Seroquel) 200 mg. The medication nurse (Staff #5) indicated that the client received this and other medications for behavior management.

On September 12, 2012, beginning at 11:51 a.m., review of Client #1's physician's order sheets (POS) dated March 1, 2012 (good for 90 days) revealed the client was prescribed Naltrexone Hydrochloride (Revia) 50 mg tablet daily (in the morning). Review of the corresponding medication administration records (MARs) for March, April and May 2012, however, failed to reflect the client had received the prescribed Revia. Continued review of Client #1's POS dated June 1, 2012 and July 1, 2012 failed to reflect any order for Revia. The client's monthly psychotropic medication review sheets from March 2012 - July 2012 reflected that the psychiatrist and review team had recommended that it continue throughout the period.

Interview with the registered nurse (RN), Staff #6, on September 13, 2012 beginning at 12:10 p.m., confirmed that Client #1 had not received Revia 50 mg daily for the period March 1, 2012 - August 27, 2012. She also confirmed that the order for Revia had not been transcribed to the client's June and July POS and MARs. Further interview with Staff #6 revealed that she discovered the issue in mid-August and reported it to her

W331

By the survey period, the new RN had discovered the medication problem involving Client #1's Revia and an investigation was in process as indicated by the surveyor. The investigation revealed that the pharmacy erroneously dropped the medication from the MARs and Physician's Orders as of March 2012. This error was not caught in the MTS internal review process for monthly medications, MARs and Physician's Orders. The medication was restarted...August 25, 2012  
No ill effects are noted during the period Client #1 did not receive the medication...10-17-12

The DON discussed the error with pharmacy. The pharmacy promised to review its internal systems to ensure no reoccurrence of this kind of error...10-17-12  
The DON revised the guidelines for signing off on the cycle medications and reviewed it with all nurses...9-13-12  
The RN and the PCP will review the POs monthly to ensure they are accurate and complete...10-27-12  
The DON will review this concern with the entire nursing team to ensure that proper reviews and auditing is done routinely to prevent such errors...11-1-12

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W 331	Continued From page 8 supervisor. According to Staff #6, the facility was conducting an internal investigation. When interviewed on September 13, 2012, at approximately 2:40 p.m., the qualified intellectual disabilities professional (QIDP), Staff #4, confirmed that the issue was currently under investigation.  [Also see W322 regarding delays in securing podiatry, orthopedic and urology services.]	W 331	
W 368	483.460(k)(1) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observation, interview and review of client records, the facility failed to ensure that clients' medications were administered in accordance with physician's orders, for one of the two clients in the sample. (Client #1)  The finding includes:  Observation on September 11, 2012, at 6:30 p.m., revealed Client #1 being administered Quetiapine Fumarate (Seroquel) 200 mg. The medication nurse (Staff #5) indicated that the client received this and other medications for behavior management.  On September 12, 2012, beginning at 11:51 a.m., review of Client #1's physician's order sheets (POS) dated March 1, 2012 (good for 90 days) revealed the client was prescribed Naltrexone Hydrochloride (Revia) 50 mg tablet daily (in the	W 368	By the survey period, the new RN had discovered the medication problem involving Client #1's Revia and an investigation was in process as indicated by the surveyor. The investigation revealed that the pharmacy erroneously dropped the medication from the MARs and Physician's Orders as of March 2012. This error was not caught in the MTS internal review process for monthly medications, MARs and Physician's Orders. The medication was restarted...August 25, 2012 No ill effects are noted during the period Client #1 did not receive the medication...10-17-12  The DON discussed the error with pharmacy. The pharmacy promised to review its internal systems to ensure no reoccurrence of this kind of error...10-17-12 The DON revised the guidelines for signing off on the cycle medications and reviewed it with all nurses...9-13-12 The RN and the PCP will review the POs monthly to ensure they are accurate and complete...10-27-12 The DON will review this concern with the entire nursing team to ensure that proper reviews and auditing is done routinely to prevent such errors...11-1-12

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W 368	Continued From page 9 morning). Review of the corresponding medication administration records (MARs) for March, April and May 2012, however, failed to reflect the client had received the prescribed Revia. Continued review of Client #1's POS dated June 1, 2012 and July 1, 2012 failed to reflect any order for Revia.  Interview with the registered nurse (RN), Staff #6, on September 13, 2012 beginning at 12:10 p.m., confirmed that Client #1 had not received Revia 50 mg daily for the period March 1, 2012 - August 27, 2012. She also confirmed that the order for Revia had not been transcribed to the client's June and July POS and MARs. Further interview with Staff #6 revealed that she discovered the issue in mid-August and reported it to her supervisor. According to Staff #6, the facility was conducting an internal investigation. When interviewed on September 13, 2012, at approximately 2:40 p.m., the qualified intellectual disabilities professional (QIDP), Staff #4, confirmed that the issue was currently under investigation.	W 368	All medication by the Pharmacist are included in the computerized orders and the RN will check these order with the Physician order and the MAR monthly. . . . . 10/31/12		
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish a system to	W 436			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/13/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE WASHINGTON, DC 20019	
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W 436	<p>Continued From page 10</p> <p>ensure each client's adaptive equipment was maintained in good repair and clients received training on the proper use of equipment, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On September 11, 2012, beginning at 7:16 a.m., Client #1 was observed wearing a helmet with a face guard (secured with a chin strap) while in the facility. He was observed wearing the helmet at day program later that morning. At 10:53 a.m., two small band aids were observed on the client's forehead after his day program case manager removed the helmet. The helmet was put back on at 11:04 a.m. after the case manager adjusted two folded wash clothes that were inside the top of the helmet.</p> <p>Later on September 11, 2012, at 4:08 p.m., Client #1 was observed vocalizing loudly and continuously upon his return home from day program. At 4:11 p.m., the client used his hand to push the helmet back on his head and rubbed his forehead. There were no band aids visible. The loud vocalizations continued without cessation, even though staff were observed offering him a snack and suggesting a variety of possible activities.</p> <p>At 4:32 p.m., the registered nurse (RN), Staff #6 approached Client #1 and informed him "You're going to get a new helmet next week....next week." She pushed his helmet back, assessed his forehead and stated "it's ok." The RN stated that a 719A form had been prepared, this helmet had "a rough patch" and it was hoped that a new helmet would "be different."</p>	W 436	<p>RN indicates that her reviews of the forehead area of client #1 demonstrates no skin breakdown, redness or changes in skin integrity caused by the existing helmet. His behavior possibly indicates there may be concerns related to the level of comfort with current helmet. The concern related to comfort was identified and client #1 was assessed for a new helmet on..... 10/9/12.</p> <p>Weekly contact with the vendor to ascertain when helmet will be received will be addressed. Projected timeframe anticipated for receipt of the new helmet is ..... 11/9/12.</p> <p>The RN Coordinator for the home will ensure that all 719A forms are completed in their entirety for individual specific adaptive and health care needs prior to submission to PCP..... 10/31/12</p>

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W 436 Continued From page 11

W 436

On September 12, 2012, at 10:45 a.m., review of Client #1's PCP notes revealed that on June 1, 2012, the PCP wrote "Re-evaluate fit of helmet." Continued review of his medical chart revealed no evidence that the helmet had been re-evaluated since then. The next PCP note, dated August 28, 2012, did not reflect any information regarding her June 1st recommendation for re-evaluating the helmet.

On September 13, 2012, at 1:01 p.m., when asked if there was documentation to verify that a helmet had been ordered, the RN presented a 719A form that was signed by the PCP. The form, however, was not dated and the RN stated "nobody has called yet." Further interview with the RN revealed that the form had not been forwarded to the designated nurse in the nursing office (Staff #7) who was responsible for scheduling medical appointments and follow-up. At 1:06 p.m., the house manager (Staff #3) indicated she was speaking on the telephone with Staff #7, who reportedly informed her she was "going to make an appointment now."

W 441 483.470(i)(1) EVACUATION DRILLS

W 441

The facility must hold evacuation drills under varied conditions.

This STANDARD is not met as evidenced by:  
Based on staff interview and record review, the facility failed to ensure that fire drills were scheduled for all times of the day and night, for three of the three clients residing in the facility. (Clients #1, #2 and #3)

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W 441 Continued From page 12  
The findings include:

W 441

1. On September 11, 2012, beginning at 2:00 p.m., review of the fire drill records in the facility for the period January 2012 - September 2012 revealed no evidence that drills had been held while clients were asleep in their beds. One fire drill had been documented at 10:00 p.m. on June 18, 2012 at which time staff wrote the clients were "in their room." Drills held at 6:00 a.m. had been documented on January 26, 2012, February 20, 2012 and March 20, 2012. Staff wrote the clients were receiving "morning care." There were no drills documented between the hours of 10:00 p.m. - 6:00 a.m.

A fire drill will be held for the overnight shift before the end of October 2012...10-30-12  
And again in December 2012 to make up the deficit...12-15-12  
The 2012 Fire Drill schedule will be developed by...12-30-12  
And will reflect drills on each shift at minimum every quarter.  
The QIDP and Facility Manager will audit implementation monthly to ensure that the drills occur and will schedule follow up drills within 7 days for any drill not implemented...10-30-12

On September 13, 2012, at 12:58 p.m., the house manager (Staff #3) indicated that she had just reviewed the 2012 fire drill reports. She confirmed there were none indicating that a drill was held during late night hours while the clients were asleep in bed.

2. On September 11, 2012, beginning at 2:00 p.m., review of the fire drill records on hand revealed there were no report forms available for the period October 2011 - December 2011. On September 13, 2012, at 12:48 p.m., Staff #3 stated that staff at their administrative office were unable to locate any fire drill reports from that period and there were no additional report forms available for review. Without documentation, it could not be determined whether any drills had been held during late night hours while the clients were asleep in bed during that 3-month period.

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R 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from September 11, 2012 through September 13, 2012. A sample of two residents was selected from a population of three men with varying degrees of intellectual disabilities of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with residents, one guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	R 000	
R 122	<p><b>4701.2 BACKGROUND CHECK REQUIREMENT</b></p> <p>Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to show evidence of having obtained a criminal background check before employing unlicensed persons, for 1 out of 15 unlicensed employees. (Staff #9)</p> <p>The finding includes:</p>	R 122	

Health Regulation & Licensing Administration  
*Catherine Moore* Director of Residential Services 10/31/12  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE DATE

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R 122 Continued From page 1

On September 11, 2012, during the entrance conference at 9:27 a.m., the house manager (Staff #3) and the qualified intellectual disabilities professional (Staff #4) agreed to make available for review the personnel records of all employees.

On September 12, 2012, beginning at 5:20 p.m., review of the personnel records for employees revealed no evidence of a current personnel file, to include a criminal background check, for Staff #9. At 5:50 p.m., the house manager said she would follow-up with the agency's main office. Some additional information was presented on September 13, 2012 and on September 24, 2012 (post survey, via facsimile). However, no personnel record (or evidence of a criminal background check) was presented for one of the direct support staff assigned to work on weekends (Staff #9).

R 122

R122

MTS Lee Street residence has 14 staff member. Attached are the 14 staff member Criminal background checks.

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I 000	INITIAL COMMENTS  A licensure survey was conducted from September 11, 2012 through September 13, 2012. A sample of two residents was selected from a population of three men with varying degrees of intellectual disabilities of intellectual disabilities.  The findings of the survey were based on observations in the home and at two day programs, interviews with residents, one guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		10/12 VED
I 136	3505.6 FIRE SAFETY  Each GHMRP shall maintain records of each simulated fire drill.  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to maintain records of each simulated fire drill, for three of the three residents of the facility. (Residents #1, #2 and #3)  The finding includes:  During the entrance conference on September 11, 2012, at approximately 9:25 a.m., the house manager (Staff #3) indicated that fire evacuation drills had been performed at least quarterly on all	I 136	A fire drill will be held for the overnight shift before the end of October 2012...10-30-12 And again in December 2012 to make up the deficit...12-15-12 The 2012 Fire Drill schedule will be developed by...12-30-12 And will reflect drills on each shift at minimum every quarter. The QIDP and Facility Manager will audit implementation monthly to ensure that the drills	

Health Regulation & Licensing Administration  
*Debbie Moore* Director of Residential Services 10/8/12  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation & Licensing Administration

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I 136	Continued From page 1  shifts. She further indicated that the fire drill records were maintained in the facility.  On September 11, 2012, beginning at 2:00 p.m., review of the fire drill records on hand revealed that they only covered the months January 2012 - September 2012. The house manager and the qualified intellectual disabilities professional (Staff #4) indicated that they would see whether drill reports from 2011 were on file at the corporate office.  No additional report forms were made available for review. On September 13, 2012, at 12:48 p.m., the house manager stated that they did not have fire drill reports available for review for the period October 2011 - December 2011.	I 136		
I 206	3509.6 PERSONNEL POLICIES  Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to show evidence that all staff and health care professionals had current health certificates on file, for 1 out of 13 direct support staff (Staff #9), 2 out of 4 nursing staff (Staff #6 and Staff #8) and 3 out of 9 consultants. (C1, C2 and C3)	I 206		

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I 206	Continued From page 2  The findings include:  On September 11, 2012, during the entrance conference at 9:27 a.m., the house manager (Staff #3) and the qualified intellectual disabilities professional (Staff #4) agreed to make available for review the personnel records of all employees.  On September 12, 2012, beginning at 5:20 p.m., review of the personnel records for employees and health care professionals revealed no evidence of current personnel records, to include health certificates, for Staff #6, #8 and #9. In addition, there was no evidence of a physician's health inventory/ certificate for four consultants. At 5:50 p.m., the house manager said she would follow-up with the agency's main office. Some additional information was presented on September 13, 2012 and on September 24, 2012 (post survey, via facsimile). However, no evidence of a physician's health inventory/ certificate was presented for the following:  1. A direct support staff assigned to work on weekends (Staff #9);  2. The registered nurse (Staff #6);  3. The director of nursing (Staff #8);  4. The primary care physician (C1);  5. The psychiatrist (C2); and,  6. The psychologist (C3).	I 206		
I 271	3513.1(b) ADMINISTRATIVE RECORDS  Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following	I 271		
			The staff that are not in compliance with health certificates has been given 2 weeks to submit updated certificates 11-2- 12. The HR department will be checking on staff compliance on quarterly bases.	

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administrative records:

(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;

This Statute is not met as evidenced by:  
Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for 1 of the 13 direct support staff (Staff #9) and 2 of the 4 nurses. (Staff #6 and #8)

The findings include:

On September 11, 2012, during the entrance conference at 9:27 a.m., the house manager (Staff #3) and the qualified intellectual disabilities professional (Staff #4) agreed to make available for review the personnel records of all employees.

On September 12, 2012, beginning at 5:20 p.m., review of the personnel records for employees and health care professionals revealed no evidence of current administrative records for Staff #6, #8 and #9 as well as the consulting pharmacist. At 5:50 p.m., the house manager said she would follow-up with the agency's main office. No additional information was presented for the aforementioned employees and consultants before the survey ended at 6:00 p.m. on September 13, 2012.

On September 24, 2012 (post survey), the facility submitted via facsimile all documentation which had been requested for the consulting pharmacist. In addition, they submitted proof that Staff #6 had a current license issued by the District of Columbia to provide registered nurse

1271

271

MTS management and the HR department will ensure that all the required administrative records of employees and consultants are made available during survey. . . . . 10/31/12

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I 271	Continued From page 4  services.  The GHPID, however, failed to make available for review any personnel records for Staff #8 and #9, and evidence that Staff #6 had a current health certificate and CPR certification.	I 271	
I 291	3514.2 RESIDENT RECORDS  Each record shall be kept current, dated, and signed by each individual who makes an entry.  This Statute is not met as evidenced by: Based on interview and record verification, the group home for persons with intellectual disabilities (GHPID) failed to ensure the maintenance of each resident's record to make certain they were current, accurate and dated, for one of the two residents in the sample. (Resident #1)  The findings include:  1. The facility failed to maintain Resident #1's records to reflect podiatry services, as follows:  On September 11, 2012, at 10:01 a.m., the registered nurse (RN), Staff #6 and the qualified intellectual disabilities professional (QIDP), Staff #4, were interviewed about an incident involving Client #1. According to the incident report, dated August 22, 2012, the client sustained an injury to a toe on his right foot and was subsequently taken to a local emergency room (ER). The ER discharge summary reflected the doctors found he had long toe nails which might have contributed to the injury. According to the RN and the QIDP, the client had received podiatry services five months earlier, in March 2012.	I 291	1. Client #1 was seen by his podiatrist on...10-3-12 He received further treatment on his toe. The podiatrist suggested that he receive a soaking treatment daily for 7 days and return in a week for reevaluation. This treatment was done and he returned to visit podiatry again on... 10-10-12 At that point the podiatrist indicated the problem was resolved (See: attached consultations)  The RN will track all medical consultation needs supported by the Nursing Office and will meet monthly with the QIDP to review the status of all upcoming consultations. The RN will report monthly to the DON the status of upcoming medical consultations...10-1-12  MTS is seeking the services of a podiatrist that will service the individuals via home visits quarterly as opposed to at their offices. A candidate has been identified...10-17-12

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NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
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I 291	<p>Continued From page 5</p> <p>On September 12, 2012, at 10:57 a.m., review of Client #1's podiatry records revealed a consultation form dated November 9, 2011. The podiatrist at that time (C4) documented having "reduced all nails" and would return "February 2012." A primary care physician (PCP) note dated March 14, 2012 indicated the client returned to the podiatrist on March 7, 2012. The PCP note did not reflect the treatments and/or recommendations made by the podiatrist on March 7, 2012. A QIDP monthly summary report indicated the client "was seen by the podiatrist on March 7, 2012; follow-up in three months." The QIDP summary also did not reflect the podiatrist's treatments and/or recommendations. The resident's record did not, however, contain a consultation form to verify that the podiatrist had assessed the resident and provided treatment.</p> <p>When interviewed again on September 13, 2012, at 1:24 p.m., the RN stated that she had seen the March 7, 2012 consultation form in the past. She further stated that she had looked through Client #1's records that morning and acknowledged that the consultation form was not in the record.</p> <p>2. The facility failed to maintain Resident #1's medical records to reflect the results of his serum laboratory tests, as follows:</p> <p>The evening medication administration was observed on September 11, 2012. At 6:31 p.m., Resident #1 was administered Simvastatin 5 mg. The medication nurse (Staff #5) indicated that the resident received this medication to control elevated serum cholesterol.</p> <p>On September 12, 2012, at approximately 3:30 p.m., review of Resident #1's laboratory study reports revealed documented labs drawn on</p>	I 291	<p>2. MTS did follow up with the lab and recovered the April 3, 2012 lab work for client #1...10-17-12 Client #1 has since had lab work done in August 2012 that demonstrated no major concerns...10-1-12</p> <p>The RN will track all medical consultations including lab work to ensure that results are routinely obtained in a timely manner. The DON will follow up with the nursing office staff to ensure that they provide effective support in the process...10-30-12</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
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I 291	<p>Continued From page 6</p> <p>August 8, 2011, November 30, 2011 and August 23, 2012. At 4:39 p.m., review of QIDP monthly summary reports for May and June 2012 revealed Resident #1 had labs drawn on April 3, 2012. Reports showing the results of those labs, however, were not observed in the resident's medical records.</p> <p>On September 13, 2012, at approximately 2:00 p.m., the QIDP examined Resident #1's records and acknowledged that the April 3, 2012 lab reports were not in the record.</p> <p>3. The facility failed to maintain Resident #1's medical records to reflect the results of dental services, as follows:</p> <p>On September 12, 2012, at approximately 11:35 a.m., review of Resident #1's dental records revealed that he had a tooth extracted on January 17, 2012. The dentist also wrote the resident's "next visit June 18, 2012." At 4:45 p.m., review of a nursing quarterly assessment, dated June 30, 2012, revealed the RN (Staff #6) wrote "last dental exam...December 20, 2011." Continued review of the medical chart failed to show evidence that the resident had returned to the dentist in June.</p> <p>On September 13, 2012, at 1:10 p.m., interview with the RN revealed that she had not previously seen the dental consultation report form dated January 17, 2012. She could not say whether the resident had been to the dentist on June 18, 2012. At 1:55 p.m., concurrent interviews with a direct support staff (Staff #2), the house manager (Staff #3) and the QIDP revealed that Staff #2 had driven Resident #1 to a dental appointment in June 2012. Staff #2 reportedly faxed a copy of the consultation sheet to the designated nurse in the</p>	I 291	<p>3. Client #1 did have the tooth removed in the January visit. Confirmation has been obtained (See: attachment)...10-1-12</p> <p>Client #1 was scheduled to see the dentist on...6-25-12 but was not seen. He has been rescheduled for...10-23-12 The RN and QIDP will meet monthly to systematically review the status of all needed medical follow up in an individualized manner...11-1-12</p>

Health Regulation & Licensing Administration

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I 291	Continued From page 7  nursing office (Staff #7) and then filed the original form in "an appointments book." They were unable to locate the form during the interview. At approximately 2:03 p.m., the QIDP said he would try to secure a copy of the June 18, 2012 dental consultation form. However, no additional information was shared before the survey ended that evening at 6:00 p.m.	I 291	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on record review and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services included both diagnosis and evaluation including identification of treatment services and services designed to prevent deterioration or further loss of function, for two of the two residents in the sample. (Residents #1 and #2)  The findings include:  1. The GHPID failed to ensure Resident #1 received timely podiatry services, as follows:  On September 11, 2012, at 10:01 a.m., the registered nurse (RN), Staff #6 and the qualified intellectual disabilities professional (QIDP), Staff #4, were interviewed about an incident involving Resident #1. According to the incident report, dated August 22, 2012, the resident sustained an	I 401	

Health Regulation & Licensing Administration

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injury to a toe on his right foot and was subsequently taken to a local emergency room (ER). The ER discharge summary reflected the doctors found he had long toe nails which might have contributed to the injury. According to the RN and the QIDP, the resident had received podiatry services six months earlier, in March 2012. Continued discussion with Staff #4 and Staff #6 revealed that the resident was supposed to receive podiatry services every three months.

On September 12, 2012, at 10:46 a.m., review of Resident #1's medical records revealed that the resident's most recent documented podiatry visit was conducted on November 9, 2011, ten months earlier. Although the QIDP stated that Resident #1 had been seen by the podiatrist on March 7, 2012, this could not be verified through record review.

When asked about podiatry services on September 13, 2012, at 1:27 p.m., the RN stated "I just got <name of a different podiatrist's> phone number... will see if she'll come work" at the facility. During the Exit Conference held September 13, 2012, Staff #4 and Staff #6 acknowledged that at least six months had passed since the resident had received podiatry care.

2. The GHPID failed to ensure re-evaluation of Resident #1's helmet, as follows:

On September 11, 2012, beginning at 7:16 a.m., Resident #1 was observed wearing a helmet with a face guard (secured with a chin strap) while in the facility. He was observed wearing the helmet at day program later that morning. At 10:53 a.m., two small band aids were observed on the resident's forehead after his day program case

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1. Client #1 was seen by his podiatrist on...10-3-12 He received further treatment on his toe. The podiatrist suggested that he receive a soaking treatment daily for 7 days and return in a week for reevaluation. This treatment was done and he returned to visit podiatry again on... 10-10-12  
At that point the podiatrist indicated the problem was resolved (See: attached consultations)

The RN will track all medical consultation needs supported by the Nursing Office and will meet monthly with the QIDP to review the status of all upcoming consultations. The RN will report monthly to the DON the status of upcoming medical consultations...10-1-12

MTS is seeking the services of a podiatrist that will service the individuals via home visits quarterly as opposed to at their offices. A candidate has been identified...10-17-12