

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5610 FIRST STREET NW WASHINGTON, DC 20011</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X5 COMPLETION DATE
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from September 18, 2012 through September 19, 2012. A sample of two clients was selected from a population of four males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and at one day program, interviews with 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.]

*Received  
10/10/12*

W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS

W 156 The facilities Incident Management Coordinator revised the investigative report form to include a signature line for CMS Administrator. The Administrator will review all investigations within five working days. 10/6/12

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for two of the four clients included in the sample. (Clients #1 and #2)

The finding includes:

On September 18, 2012, beginning at 9:59 a.m., review of the facility's incident management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia A. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>10/10/12</i>
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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 156 Continued From page 1

records revealed an incident (allegation of neglect) report dated February 14, 2012. According to the incident, registered nurse #1 (RN#1) had reasons to believe that Client #1 and Client #2 were not fed their breakfast when she arrived to the facility at 7:30 a.m. The assigned staff (Staff #1) reportedly had fed the clients their breakfast. However, RN#1 observed that no food had been prepared for any of the individuals that morning. Review of the corresponding investigative report revealed the incident management coordinator (IMC) completed the investigation on February 21, 2012. Further review revealed there was no documented evidence that the results of the investigation were reported to the administrator within five working days.

Interview with the incident management coordinator (IMC), on September 19, 2012, at approximately 4:00 p.m., revealed that the results for the aforementioned incidents were reviewed by the facility's administrators within five working days. The IMC however, could not produce any written evidence that the administrator had review the results of the investigations within five working days.

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, interview and record review, the facility failed to ensure the qualified

W 156

W 159

The QIDP will develop a plan that will ensure that Client #2's communication device is implemented into the day program which will also include training of the staff. QIDP and Residential Manager will monitor monthly for implementation.  
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W 159	<p>Continued From page 2</p> <p>intellectual disability professional (QIDP) coordinated and integrated services, for one of two clients included in the sample. (Clients #1)</p> <p>The finding includes:</p> <p>On September 18, 2012, beginning at 9:47 a.m., the surveyor spoke to Client #1 while he sat at the dining table. The client did not speak back. Interview with Staff #1 (who was assigned to Client #1) revealed that Client #1 was non-verbal and was also blind. When asked, Staff #1 stated that Client #1 communicated through facial gestures. Continued observations in the facility from 11:40 a.m. - 5:55 p.m., revealed Client #1 had a morning snack, lunch, afternoon snack and dinner. He was also observed to use the bathroom several times throughout this time period. At approximately 6:00 p.m., the residential coordinator #1 (RC #1) placed a communication device in front of Client #1 after dinner. The device had two (2) squares on it. When RC #1 pressed one square, a voice recording said ready to eat and the second square recording said go to the bathroom. The client was not observed to manipulate the device. On September 19, 2012, from 9:49 p.m. to 10:42 a.m., observations conducted at the day program revealed that Client #1 was not observed to use a communication device. During this timeframe, Client #1 was taken to the bathroom because he had an accident.</p> <p>Interview with RC #1 on September 18, 2012, at approximately 6:05 p.m., revealed that the Client #1's communication device was recommended for the client to express himself when he needed to use the bathroom or wanted something to eat.</p>	W 159		
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W 159 Continued From page 3

Further interview revealed that the communication device was to be used as part of Client #1's habilitation (goals and objectives).

Review of Client #1's individual support plan (ISP) records on September 19, 2012, at approximately 12:25 p.m., revealed an ISP dated October 18, 2011, and a speech/language pathology assessment dated October 16, 2010. Both confirmed RC #1's interview conducted on September 18, 2012.

On September 19, 2012, at approximately 4:10 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the "Rocking Say It - Play It" device had not been integrated and coordinated as part of Client #1's active treatment while at the day program.

W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN

The individual program plan must include opportunities for client choice and self-management.

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility staff failed to ensure client choice and self-management during meals, for one of the two clients included in the sample. (Clients #1)

The finding includes:

On September 18, 2012, at 9:50 a.m., Client #1 was observed sitting at the dining table. The client appeared to be visually impaired. Interview with Staff #1 (who was assigned to Client #1) confirmed that Client #1 was blind. At 10:10 a.m.,

W 159

W 247

All staff will be re-trained on Client #1 meal time protocol. Both the House Manager and the QIDP will continue to observe during meal Time to ensure all meal time protocols are followed.

10/19/12

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W 247 Continued From page 4

Client #1 received a morning snack, which consisted of Ritz peanut crackers and chocolate pudding. Staff #1 fed the client the morning snacks using a built-up spoon. Staff #1 also held Client #1's cup up to his mouth while he consumed his beverage. During lunchtime at 12:20 p.m., Staff #1 was observed to feed the client his lunch (mixed vegetables, bite size hamburger patty and wheat bread) using the built-up spoon. At 3:17 p.m., Staff #2 placed honey graham crackers into a bowl, broke the crackers into bite size pieces and fed the crackers to Client #1. Later that evening at 5:33 p.m., dinner observations revealed Staff #6 placed Client #1's hand on a built-up spoon, scooped the food up with a spoon using hand over hand assistance and guided the food to the client's mouth. This observation occurred until the dinner meal was completed at 5:46 p.m.

W 247

On September 19, 2012, at 12:58 p.m., interview with Staff #1 and Staff #2 who prepared the lunch and snacks both revealed that Client #1 could feed himself with minimum physical assistance. Further interview revealed that going forward; they both would provide Client #1 with the opportunity to feed himself during all meals and snacks.

At the time of the survey, the facility's staff failed to allow clients to exercise their independence and allow options of choice.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed

W 249

All staff will be re-trained on Client #1's communication program and communication goals in order to encourage and facilitate implementation of Client #1's communication training program.

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W 249 Continued From page 5  
interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility staff failed to ensure each client's communication training programs were implemented consistently, for one of the two clients in the sample. (Client #1)

The finding includes:

On September 18, 2012, beginning at 9:47 a.m., the surveyor spoke to Client #1 while he sat at the dining table. The client did not speak back. Interview with Staff #1 (who was assigned to Client #1) revealed that Client #1 was non-verbal and was also blind. When asked, Staff #1 stated that Client #1 communicated through facial gestures. Continued observations in the facility from 11:40 a.m. -5:55 p.m., revealed Client #1 had a morning snack, lunch, afternoon snack and dinner. He was also observed to use the bathroom several times throughout this time period. At approximately 6:00 p.m., the residential coordinator #1 (RC #1) placed a communication device in front of Client #1 after dinner. The device had two (2) squares on it. When RC #1 pressed one square, a voice recording said ready to eat and the second square recording said go to the bathroom. The client was not observed to manipulate the device.

Interview with RC #1 on September 18, 2012, at

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W 249 Continued From page 6

approximately 6:05 p.m., revealed that the Client #1's communication device was recommended for the client to express himself when he needed to use the bathroom or wanted something to eat. Further interview revealed that the communication device was to be used as part of Client #1's habilitation (goals and objectives).

On September 19, 2012, at approximately 12:25 p.m., review of Client #1's individual support plan (ISP) dated October 10, 2011, revealed the client had an objective that stated "given moderate physical assistance, the client will express himself using a Rocking Say It - Play It 3 out of 5 trials for 12 consecutive months". Continued record review revealed a speech/language pathology assessment dated April 14, 2010. The assessment confirmed that the "Rocking Say It - Play It" communication device was used in the home to encourage Client #1 to express intent for eating and toileting.

At the time of the survey, facility staff failed to encourage and facilitate implementation of Client #1's communication training program.

W 440 483.470(I)(1) EVACUATION DRILLS

The facility must hold evacuation drills at least quarterly for each shift of personnel.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4)

The finding includes:

W 249

W 440

Fire Drills will be conducted on the 8-4 shifts for the weekend and weekday shifts. The QIDP and the Residential Manager will monitor monthly fire drills for all shifts to ensure they are completed in a timely fashion. 10/19/12

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W 440 Continued From page 7

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On September 18, 2012, at 12:07 p.m., interview with the residential coordinator (RC #1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that the weekends shifts were the same as weekday.

Review of the facility's fire drill records on September 18, 2012, beginning 12:10 p.m. revealed that no drills were held during the weekday shift on 8:00 a.m. - 4:00 p.m. from January 2012 through March 2012. Continued interview with the RC #1 on September 19, 2012, at approximately 3:50 p.m., verified that fire drills were not conducted during the aforementioned timeframe listed above.

W 440

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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from September 18, 2012 through September 19, 2012. A sample of two residents was selected from a population of four males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interview with direct support staff, nursing and administrative staff, as well as a review of resident administrative records, including incident reports.</p>	I 000		
I 090	<p><b>3504.1 HOUSEKEEPING</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for four of the four residents of the facility. (Residents #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>Observation and interview with residential coordinator #1 (RC #1) on September 19, 2012, beginning at 2:50 p.m., revealed the following:</p>	I 090		

Health Regulation & Licensing Administration

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

*Rayam Puerto*  
TITLE

(X8) DATE

*10/10/12*

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I 090	Continued From page 1  1. The two (2) rear eyes located on top of the stove appeared to be inoperable.  2. The short rail hinges leading to the upstairs were broken.  3. The bathroom knob located in the bathroom on the second level was observed with a dark green color.  RC #1 confirmed the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090	1. The two rear eyes located on the Top of the stove were repaired. 2. The short rail hinges leading to the upstairs were repaired. 3. The bathroom knob located in the bathroom on the second floor was replaced.	9/20/12 9/20/12 9/20/12
1135 3505.5	FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  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 hold evacuation drills quarterly on all shifts, for four of the four residents residing in the GHPID. (Residents #1, #2, #3 and #4)  The finding includes:  The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On September 18, 2012, at 12:07 p.m., interview with the residential coordinator (RC #1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that the weekends	1135	1. Cross Reference W440.	10/19/12

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1135	Continued From page 2  Review of the GHPID's fire drill records on September 18, 2012, beginning 12:10 p.m. revealed that no drills were held during the weekday shift on 8:00 a.m. - 4:00 p.m. from January 2012 through March 2012. Continued interview with the RC #1 on September 19, 2012, at approximately 3:50 p.m., verified that fire drills were not conducted during the aforementioned timeframe listed above.	1135		
1180	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, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to provide adequate administrative support to ensure effective integration and coordination of each resident's habilitation and active treatment needs, for one of the two residents in the sample. (Resident #1)  The finding Includes:  On September 18, 2012, beginning at 9:47 a.m., the surveyor spoke to Client #1 while he sat at the dining table. The client did not speak back Interview with Staff #1 (who was assigned to Client #1) revealed that Client #1 was non-verbal and was also blind. When asked, Staff #1 stated that Client #1 communicated through facial gestures. Continued observations in the facility from 11:40 a.m.- 5:55 p.m., revealed Client #1 had a morning snack, lunch, afternoon snack and	1180	2. Cross reference W159.	10/19/12

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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5610 FIRST STREET NW WASHINGTON, DC 20011</b>		
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I 180	<p>Continued From page 3</p> <p>dinner. He was also observed to use the bathroom several times throughout this time period. At approximately 6:00 p.m., the residential coordinator #1 (RC #1) placed a communication device in front of Client #1 after dinner. The device had two (2) squares on it. When RC #1 pressed one square, a voice recording said ready to eat and the second square recording said go to the bathroom. The client was not observed to manipulate the device. On September 19, 2012, from 9:49 p.m. to 10:42 a.m., observations conducted at the day program revealed that Client #1 was not observed to use a communication device. During this timeframe, Client #1 was taken to the bathroom because he had an accident.</p> <p>Interview with RC #1 on September 18, 2012, at approximately 6:05 p.m., revealed that the Client #1's communication device was recommended for the client to express himself when he needed to use the bathroom or wanted something to eat. Further interview revealed that the communication device was to be used as part of Client #1's habilitation (goals and objectives).</p> <p>Review of Client #1's individual support plan (ISP) records on September 19, 2012, at approximately 12:25 p.m., revealed an ISP dated October 18, 2011, and a speech/language pathology assessment dated October 16, 2010. Both confirmed RC #1's interview conducted on September 18, 2012.</p> <p>On September 19, 2012, at approximately 4:10 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the "Rocking Say It - Play It" device had not been integrated and coordinated as part of Client #1's active treatment while at the day program.</p>	I 180		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
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I 422	<p><b>3521.3 HABILITATION AND TRAINING</b></p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that resident's training objective was implemented in accordance with their individual support plan (ISP), for one of the two residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On September 18, 2012, beginning at 9:47 a.m., the surveyor spoke to Resident #1 while he sat at the dining table. The resident did not speak back. Interview with Staff #1 (who was assigned to Resident #1) revealed that Resident #1 was non-verbal and was also blind. When asked, Staff #1 stated that Resident #1 communicated through facial gestures. Continued observations in the GHPID from 11:40 a.m.- 5:55 p.m., revealed Resident #1 had a morning snack, lunch, afternoon snack and dinner. He was also observed to use the bathroom several times throughout this time period. At approximately 6:00 p.m., the residential coordinator #1 (RC #1) placed a communication device in front of Resident #1 after dinner. The device had two (2) squares on it. When RC #1 pressed one square, a voice recording said ready to eat and the second square recording said go to the bathroom. The resident was not observed to manipulate the device.</p> <p>Interview with RC #1 on September 18, 2012, at approximately 6:05 p.m., revealed that the</p>	I 422		
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5610 FIRST STREET NW WASHINGTON, DC 20011</b>		
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1 422	Continued From page 5  Resident #1's communication device was recommended for the resident to express himself when he needed to use the bathroom or wanted something to eat. Further interview revealed that the communication device was to be used as part of Resident #1's habilitation (goals and objectives).  On September 19, 2012, at approximately 12:25 p.m., review of Resident #1's individual support plan (ISP) dated October 10, 2011, revealed the resident had an objective that stated "given moderate physical assistance, the resident will express himself using a Rocking Say It - Play It 3 out of 5 trials for 12 consecutive months" Continued record review revealed a speech/language pathology assessment dated April 14, 2010. The assessment confirmed that the "Rocking Say It - Play It" communication device was used in the home to encourage Resident #1 to express intent for eating and toileting.  At the time of the survey, GHPID staff failed to encourage and facilitate implementation of Resident #1's communication training program.	1 422	3. Cross Reference W249.	10/19/12	