

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

PRINTED: 06/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3816 ALBERMARLE STREET NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS A recertification survey was conducted from May 21, 2013 through May 22, 2013. A sample of three clients was selected from a population of six 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 two day programs, interviews with 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 000	<p><i>Received 6/12/13 DOH-HRLA-ICFO</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was effectively trained to manage the provisions outlined in each client's nutritional assessment and physical therapy assessment, for one of the three clients in the sample. (Client #3) The finding includes: 1. The facility failed to ensure staff used Client #3's gait belt in accordance with the physical	W 189			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Christopher A. Reese* TITLE *Program Director* (X6) DATE *6/12/13*

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 189	<p>Continued From page 1 therapy assessment, as evidenced below:</p> <p>On May 21, 2013, beginning at 11:17 a.m., observations conducted at the day program revealed Client #3 was sitting down on the patio. The client was wearing a blue gait belt. At 11:57 a.m., the one to one staff (Staff #1) assigned to Client #3 (from the group home), was observed to hold Client #3 under his arms while assisting the client to the bathroom. A few minutes later after exiting the bathroom, Staff #1 continued to hold Client #3 under his arms as he assisted the client to the table for lunch. At no time, did Staff #1 use the gait belt to assist Client #3. At approximately 12:15 p.m., interview with Staff #1 revealed that he did not use a gait belt to assist Client #3 with ambulating because the client leaned forward when the gait belt was used. Further interview revealed he was trained on how to use a gait belt but was not familiar with the walking protocol.</p> <p>On May 22, 2013, at 11:45 a.m., review of Client #3's record revealed a walking protocol dated July 18, 2008. The protocol revealed that when Client #3 began to lean forward or walk too fast, staff should instruct the client to slow down. If the client did not slow down, have him stop walking and start again. At approximately 11:50 a.m., review of Client #3's physical therapy assessment dated November 8, 2012, revealed the client was at risk for falls and required a gait belt during transfers and while ambulating.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) #1 at approximately 3:00 p.m., revealed the walking protocol dated July 18, 2008, was not the current protocol. At approximately 3:15 p.m., QIDP #1 provided the</p>	W 189	<p>1. Staff #1 will receive additional training on the walking protocol with the use of the gait belt for client #3. Staff #1 will be given a written competence test to ensure that training was effective. QIDP/ Residential Manager will visit day program monthly to make observation of staff #1, correct implementation of walking protocol and gait belt.</p>	6/8/13	

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W 189	<p>Continued From page 2</p> <p>surveyor with a current walking protocol which was not dated or signed. The protocol revealed the following:</p> <ul style="list-style-type: none"> a. Fasten the gait belt around the client's waist with the buckle placed in front of the client. b. Check the tightness of the gait belt. The belt should fit snugly, but you should be able to slip your fingers between the belt and the client's waist. c. Assist the client to a standing position. d. Place one hand on waist side of the client's gait belt and place the other hand on the back of the gait belt. e. Instruct the client to walk forward beginning with his strong leg. f. Walk to the side and slightly behind the individual. g. Assist the client into a chair or onto the side of the bed after walking. <p>On May 22, 2013, at approximately 1:55 p.m., review of the in-service training records revealed all staff received training on the current walking protocol on March 7, 2013. Observations on May 21, 2013, revealed that training was not effective.</p> <p>2. The facility failed to offer Client #3 two hours after his meal in accordance with the nutritional assessment, as evidenced below:</p> <p>On May 21, 2013, beginning at 12:00 p.m.,</p>	W 189	<p>The current walking protocol for client #1 was dated and signed.</p> <p>2. Staff #1 will receive training and given a written competence test on client #1 nutritional needs and assessment. Client #1 recommendation from his nutritional assessment will be followed as ordered and documented. QIDP/Residential Manager will visit day program to coordinate services</p>	5/24/13	

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W 189	Continued From page 3 observations conducted at the day program revealed Staff #1 assisted Client #3 to the table for lunch. Staff #1 served Client #3 a bologna sandwich, potato chips and a ensure drink supplement. At 12:04 p.m., Client #3 drank some of his ensure when he began to eat his lunch. At 12:06 p.m., interview with Staff #1 revealed that he brought the client's lunch from home with his ensure to the day program five (5) days a week. On May 22, 2013, beginning at 10:48 a.m., review of Client #3's nutritional assessment dated July 10, 2012, recommended that the client receive ensure two hours after his meal 3 times a day. At approximately 2:00 p.m., review of the staff in-service training records revealed that all staff including Staff #1 had received training on Client #3's nutritional needs on April 17, 2013. Observations on May 21, 2013, however, indicated that the training was not effective.	W 189	and monitor for implementation of recommendation. Client #1 lunch will include an additional beverage for him to drink with his lunch.	6/28/13	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was effectively trained to manage the provisions outlined in each client's nutritional assessment	W 194			

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W 194	<p>Continued From page 4 and physical therapy assessment, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>1. The facility failed to ensure staff used Client #3's gait belt in accordance with the physical therapy assessment, as evidenced below:</p> <p>On May 21, 2013, beginning at 11:17 a.m., observations conducted at the day program revealed Client #3 was sitting down on the patio. The client was wearing a blue gait belt. At 11:57 a.m., the one to one staff (Staff #1) assigned to Client #3 (from the group home), was observed to hold Client #3 under his arms while assisting the client to the bathroom. A few minutes later after exiting the bathroom, Staff #1 continued to hold Client #3 under his arms as he assisted the client to the table for lunch. At no time, did Staff #1 use the gait belt to assist Client #3. At approximately 12:15 p.m., interview with Staff #1 revealed that he did not use a gait belt to assist Client #3 with ambulating because the client leaned forward when the gait belt was used. Further interview revealed he was trained on how to use a gait belt but was not familiar with the walking protocol.</p> <p>On May 22, 2013, at 11:45 a.m., review of Client #3's record revealed a walking protocol dated July 18, 2008. The protocol revealed that when Client #3 began to lean forward or walk too fast, staff should instruct the client to slow down. If the client did not slow down, have him stop walking and start again. At approximately 11:50 a.m., review of Client #3's physical therapy assessment dated November 8, 2012, revealed the client was at risk for falls and required a gait belt during</p>	W 194	Cross-reference W189 (1)	6/28/13	

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W 194	<p>Continued From page 5 transfers and while ambulating.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) #1 at approximately 3:00 p.m., revealed the walking protocol dated July 18, 2008, was not the current protocol. At approximately 3:15 p.m., QIDP #1 provided the surveyor with a current walking protocol which was not dated or signed. The protocol revealed the following:</p> <ul style="list-style-type: none"> a. Fasten the gait belt around the client's waist with the buckle placed in front of the client. b. Check the tightness of the gait belt. The belt should fit snugly, but you should be able to slip your fingers between the belt and the client's waist. c. Assist the client to a standing position. d. Place one hand on waist side of the client's gait belt and place the other hand on the back of the gait belt. e. Instruct the client to walk forward beginning with his strong leg. f. Walk to the side and slightly behind the individual. g. Assist the client into a chair or onto the side of the bed after walking. <p>On May 21, 2013, Staff #1 who was observed assisting Client #3 at his day program did not implement his walking protocol as written. Staff #1 did not use the client's gait belt after he</p>	W 194	Cross-reference W189 (2)	6/28/13	

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W 194	<p>Continued From page 6</p> <p>assisted the client to a standing position.</p> <p>2. The facility failed to offer Client #3's ensure two hours after his meal in accordance with the nutritional assessment, as evidenced below:</p> <p>On May 21, 2013, beginning at 12:00 p.m., observations conducted at the day program revealed Staff #1 assisted Client #3 to the table for lunch. Staff #1 served Client #3 a bologna sandwich, potato chips and a ensure drink supplement. At 12:04 p.m., Client #3 drank some of his ensure when he began to eat his lunch. At 12:06 p.m., interview with Staff #1 revealed that he brought the client's lunch from home with his ensure to the day program five (5) days a week.</p> <p>On May 22, 2013, beginning at 10:48 a.m., review of Client #3's nutritional assessment dated July 10, 2012, recommended that the client receive ensure two hours after his meal 3 times a day. At approximately 2:00 p.m., review of the staff in-service training records revealed that all staff including Staff #1 had received training on Client #3's nutritional needs on April 17, 2013. Observations on May 21, 2013, however, indicated that the training was not effective.</p> <p>On May 22, 2013, interview with Staff #1 revealed that he was trained on the client's nutritional needs, but was not aware that ensure was to be offered two hours after the client's meal.</p>	W 194	Cross-reference W189 (2)	6/28/13	

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Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		
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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 21, 2013 through May 22, 2013. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with 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>	I 000			
I 090	<p>3504.1 HOUSEKEEPING</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 individuals with intellectual disabilities (GHIID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>Observation during the inspection of the environment on May 22, 2013, beginning 2:50</p>	I 090			

Health Regulation & Licensing Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8090

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If continuation sheet 1 of 2

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 21, 2013 through May 22, 2013. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with 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>	1 000		
1 090	<p>3504.1 HOUSEKEEPING</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 individuals with intellectual disabilities (GHIID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>Observation during the inspection of the environment on May 22, 2013, beginning 2:50</p>	1 090		

Health Regulation & Licensing Administration

Constance A. Reese LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Program Director TITLE

(X6) DATE
6/12/13

STATE FORM

0690

B71F11

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I 090	Continued From page 1 p.m., revealed the following: 1. The toilet handle located on the third floor was observed to be detached from the toilet which made it difficult to flush the toilet. 2. The toilet drain stopper located on the second floor was observed to be inoperable. House Manager #1 (HM1) who was present during the inspection, confirmed the above findings. HM1 stated she would address the findings with maintenance.	I 090	1. The toilet handle located on the third floor was repaired. 2. A new toilet drain stopper was purchased to replace the inoperable stopper in the 2nd floor bathroom. The Maintenance Supervisor will check toilets monthly for any malfunctions.	5/24/13	5/24/13