

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

PRINTED: 06/01/2012  
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  05/11/2012
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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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(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 May 9, 2012 through May 11, 2012. A sample of three clients was selected from a population of six men with various 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 three day programs, interviews with direct support staff, 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 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met individual's need, for one of the three sampled clients with prescribed adaptive feeding equipment. (Client #2)

The finding includes:

The facility failed to ensure that Client #2's day program used adaptive eating equipment, as evidenced below:

*Received 6/1/12*

Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
800 North Capitol St., N.E.  
Washington, D.C. 20002

W 120 Client #2's day program will be sent a plate riser and a copy of the OT assessment that recommended the plate riser. QIDP will visit day program quarterly to ensure the use of the plate riser.

6/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Constantine A. Reese</i>	TITLE <i>Program Director</i>	X6 DATE <i>6/1/12</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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 120 Continued From page 1

W 120

On May 9, 2012, at 4:56 p.m., Staff #1 was observed in the kitchen preparing Client #2's dinner by placing a chopped cold cut sandwich and raw vegetables into a sectional divided plate. At 5:21 p.m., Client #2's dinner was placed on a plate riser as he consumed his meal independently while remaining in an upright position. Observations conducted at the day program on May 10, 2012, beginning at 12:13 p.m., revealed Client #2 was served his lunch meal which consisted of collard greens, macaroni and cheese and fish in a sectional divided plate. Further observations revealed the client's head and neck remained over top of his plate as he consumed his lunch meal independently.

Day program staff (Staff #1) was interviewed on the same day at 12:30 p.m., to ascertain whether Client #2 used a plate riser during lunch while at the day program. Staff #1 responded by saying, "we do not use it here". Staff #1 then stated that the plate riser was not part of the client's mealtime protocol. At approximately 12:55 p.m., interview with the day program's program director (PD) revealed that the client used the plate riser here in the past. The PD did state however, that the plate riser was sent back facility because there was no assessment that indicated that the client needed a plate riser while feeding.

On May 11, 2012, at approximately 3:15 p.m., the qualified intellectual disabilities professional (QIDP) was interviewed. The QIDP revealed that the day program should be using Client #2's plate riser during lunch time. Further interview with the QIDP revealed that she had not observed a meal observation at Client #2's day program since September 2011. The QIDP stated that she

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w 120	Continued From page 2  thought the day program was using Client #2's plate riser during lunch time. When asked, the QIDP stated that there was an assessment completed by the occupational therapist (OT) that recommended the plate riser during mealtime.  Record verification on May 11, 2012, at approximately 3:25 p.m., revealed an OT assessment dated September 13, 2010. According to the assessment, the OT recommended the use of the plate riser to prevent Client #2 from slouching over when he eats. Further review revealed that plate riser would help him to sit in an upright position.	W 120	
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's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination, monitoring, and implementation of each client's habilitation and planning, for two of the three sampled clients. (Clients #2 and #3)  The findings include:  1. The QIDP failed to ensure that Client #3's hair was kept short to prevent the client from pulling his hair, as recommended by the interdisciplinary team (IDT).  On May 9, 2012, at 4:35 p.m., evening	W 159	1. Client #3's hair will be cut at least once weekly. QIDP and House Manager will ensure that his hair is kept cut short.  6/1/12

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W 159 Continued From page 3

W 159

observations revealed Client #3 was sitting at the dining table folding a news paper. The client appeared to be in need of a hair cut and a shaving. The client's hair appeared to be approximately 1/4 to 1/2 of an inch long. Further observations revealed the client had two patches of hair missing from the left side of his head about the size of a half dollar. There was a smaller patch of hair also observed missing from the back side of his head. At 4:37 p.m., when asked, the house manager (HM) stated that Client #3 pulled his hair out in the three spots where his hair was missing. Further interview with the HM revealed that the behavior of hair pulling was part of his behavior support plan (BSP).

Interview with Staff #1 (1:1 staff assigned to Client #3) on May 10, 2012, at 11:12 a.m., revealed the Client #3 had a behavior of pulling his hair out. Further interview with Staff #1 revealed that the HM, who usually cut the client's hair, transferred to another facility approximately three (3) weeks ago. Staff #1 stated, as a result of Client #1's hair not being cut in over a month, the client pulled his hair out in the aforementioned 3 areas located on his head. Staff #1 also added that during the individual support plan (ISP) meeting that occurred in February 2012, the interdisciplinary team agreed to keep the client's hair cut low to prevent him from pulling his hair out.

Review of Client #3's behavior support plan (BSP) dated August 3, 2011, on May 11, 2012, at 12:19 p.m., revealed the client had a target behavior of pulling his hair. Further review of the BSP in the section entitled "Preventative

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W 159 Continued From page 4

W 159

Strategies", revealed to keep the client's hair cut short.

Interview with the qualified intellectual disabilities professional (QIDP) on May 11, 2012, at approximately 3:30 p.m., confirmed Staff #1's interview that the HM who usually cut the client's hair was transferred to another facility. Further interview with the QIDP revealed that the facility was in the process of trying to find a local barber shop in the area.

2. Cross-refer to W120. The QIDP failed to monitor Client #2's day program to ensure that the recommended adaptive eating equipment was used during lunch time.

2. Cross reference W120

6/1/12

On May 9, 2012, at 4:56 p.m., Staff #1 was observed in the kitchen preparing Client #2's dinner by placing a chopped cold cut sandwich and raw vegetables into a sectional divided plate. At 5:21 p.m., Client #2's dinner was placed on a plate riser as he consumed his meal independently while remaining in an upright position. Observations conducted at the day program on May 10, 2012, beginning at 12:13 p.m., revealed Client #2 was served his lunch meal which consisted of collard greens, macaroni and cheese and fish in a sectional divided plate. Further observations revealed the client's head and neck remained over top of his plate as he consumed his lunch meal independently.

Day program staff (Staff #1) was interviewed on the same day at 12:30 p.m., to ascertain whether Client #2 used a plate riser during lunch while at the day program. Staff #1 responded by saying, "we do not use it here". Staff #1 then stated that

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W 159 Continued From page 5

W 159

the plate riser was not part of the client's mealtime protocol. At approximately 12:55 p.m., interview with the day program's program director (PD) revealed that the client used the plate riser here in the past. The PD did state however, that the plate riser was sent back facility because there was no assessment that indicated that the client needed a plate riser while feeding.

On May 11, 2012, at approximately 3:15 p.m., the qualified intellectual disabilities professional (QIDP) was interviewed. The QIDP revealed that the day program should be using Client #2's plate riser during lunch time. Further interview with the QIDP revealed that she had not observed a meal observation at Client #2's day program since September 2011. The QIDP stated that she thought the day program was using Client #2's plate riser during lunch time.

Review of the day program's visitors log records on May 10, 2012, at approximately 12:55 p.m., revealed that QIDP last visit to the day program was on July 29, 2010.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

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.

Staff will be trained on the use gait belt. QIDP and House Manager will ensure each staff is appropriately using the gait belt and will monitor daily for proper usage.

6/8/12

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of the three

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W 189 Continued From page 6  
clients with an unsteady gait. (Client #2)

W 189

The finding includes:

On May 9, 2012, at 4:37 p.m., Client #2 was observed walking from the living room area, to kitchen and back to the living room area with an unsteady gait. The client appeared to have a blue gait belt on with loops attached to the back of the gait belt. At 4:48 p.m., Client #2 got up from the dining table and stumbled slightly as he walked to the kitchen to put his plate into the sink independently. At 5:16 p.m., the client was observed independently walking down the steps from his bedroom to the living room area without his gait belt. Continued observations revealed Client #2 was observed ambulating independently throughout the remainder of the survey without the use of his gait belt.

Review of Client #2's physical therapy (PT) assessment dated May 22, 2011, on May 11, 2012, at 11:41 a.m., revealed the client walked with an unsteady gait. Further review of the assessment revealed that staff supervision was recommended for Client #2's safety while ambulating. The PT also recommended the use of the gait belt for safety. Continued review of Client #2's records revealed current physician's orders dated May 2012. According to the orders, the gait belt was to be use while ambulating.

Interview with Staff #2 on May 11, 2012, at approximately 3:30 p.m., revealed that on May 9, 2012, he was responsible for Client #2 during the 4 PM - 12 AM shift. Further interview with Staff #2 revealed that he did not support the client with the use of the gait belt while he ambulated each

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W 189 Continued From page 7

W 189

time throughout the evening. When asked, Staff #2 stated that he had received training on the use of Client #2's gait belt.

The facility's staff in-service training record was reviewed on May 11, 2012, at approximately 4:00 p.m. There was an agenda that staff members from multiple shifts had been trained on the use of the gait belt for Client #2. However, there was no signature sheet attached with the agenda indicating what staff had actually received the training.

Interview with the facility's qualified Intellectual disabilities professional (QIDP) on May 11, 2012, at 4:17 p.m., revealed that all staff had been trained on the use of Client #2's gait belt. Further interview revealed that she could not locate the signature sheets for the training on the use of the gait belt.

At the time of the survey, there was no documented evidenced that staff had been trained on the use of Client #2's gait belt as recommended.

Health Regulation & Licensing Administration

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1000 INITIAL COMMENTS

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A licensure survey was conducted from May 9, 2012 through May 11, 2012. A sample of three residents was selected from a population of six men with various degrees intellectual disabilities.

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

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

1180 3508.1 ADMINISTRATIVE SUPPORT

1180

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 ensure adequate administrative support had been provided to effectively meet the needs, for two of the three residents included in the sample. (Residents #2 and #3)

The findings include:

1. The QIDP failed to ensure that Resident #3's hair was kept short to prevent the resident from pulling his hair, as recommended by the interdisciplinary team (IDT).

Cross Reference W159 #1

6/1/12

Health Regulation & Licensing Administration <i>Constance A. Reese</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Program Director</i>	(X6) DATE <i>6/1/12</i>
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## Health Regulation &amp; Licensing Administration

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1180 Continued From page 1

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On May 9, 2012, at 4:35 p.m., evening observations revealed Resident #3 was sitting at the dining table folding a news paper. The resident appeared to be in need of a hair cut and a shaving. The resident's hair appeared to be approximately 1/4 to 1/2 of an inch long. Further observations revealed the resident had two patches of hair missing from the left side of his head about the size of a half dollar. There was a smaller patch of hair also observed missing from the back side of his head. At 4:37 p.m., when asked, the house manager (HM) stated that Resident #3 pulled his hair out in the three spots where his hair was missing. Further interview with the HM revealed that the behavior of hair pulling was part of his behavior support plan (BSP).

Interview with Staff #1 (1:1 staff assigned to Resident #3) on May 10, 2012, at 11:12 a.m., revealed the Resident #3 had a behavior of pulling his hair out. Further interview with Staff #1 revealed that the HM, who usually cut the resident's hair, transferred to another GHPID approximately three (3) weeks ago. Staff #1 stated, as a result of Resident #1's hair not being cut in over a month, the resident pulled his hair out in the aforementioned 3 areas located on his head. Staff #1 also added that during the individual support plan (ISP) meeting that occurred in February 2012, the interdisciplinary team agreed to keep the resident's hair cut low to prevent him from pulling his hair out.

Review of Resident #3's behavior support plan (BSP) dated August 3, 2011, on May 11, 2012, at 12:19 p.m., revealed the resident had a target behavior of pulling his hair. Further review of the BSP in the section entitled "Preventative Strategies", revealed to keep the resident's hair

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cut short.

1180

Interview with the qualified intellectual disabilities professional (QIDP) on May 11, 2012, at approximately 3:30 p.m., confirmed Staff #1's interview that the HM who usually cut the resident's hair was transferred to another GHPID. Further interview with the QIDP revealed that the GHPID was in the process of trying to find a local barber shop in the area.

2. Cross-refer to W120. The QIDP failed to monitor Resident #2's day program to ensure that the recommended adaptive eating equipment was used during lunch time.

Cross Reference W120

6/1/12

On May 9, 2012, at 4:56 p.m., Staff #1 was observed in the kitchen preparing Resident #2's dinner by placing a chopped cold cut sandwich and raw vegetables into a sectional divided plate. At 5:21 p.m., Resident #2's dinner was placed on a plate riser as he consumed his meal independently while remaining in an upright position. Observations conducted at the day program on May 10, 2012, beginning at 12:13 p.m., revealed Resident #2 was served his lunch meal which consisted of collard greens, macaroni and cheese and fish in a sectional divided plate. Further observations revealed the resident's head and neck remained over top of his plate as he consumed his lunch meal independently.

Day program staff (Staff #1) was interviewed on the same day at 12:30 p.m., to ascertain whether Resident #2 used a plate riser during lunch while at the day program. Staff #1 responded by saying, "we do not use it here". Staff #1 then stated that the plate riser was not part of the resident's mealtime protocol. At approximately 12:55 p.m., interview with the day program's

Health Regulation & Licensing Administration

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program director (PD) revealed that the resident used the plate riser here in the past. The PD did state however, that the plate riser was sent back GHPID because there was no assessment that indicated that the resident needed a plate riser while feeding.

On May 11, 2012, at approximately 3:15 p.m., the qualified intellectual disabilities professional (QIDP) was interviewed. The QIDP revealed that the day program should be using Resident #2's plate riser during lunch time. Further Interview with the QIDP revealed that she had not observed a meal observation at Resident #2's day program since September 2011. The QIDP stated that she thought the day program was using Resident #2's plate riser during lunch time.

Review of the day program's visitors log records on May 10, 2012, at approximately 12:55 p.m., revealed that QIDP last visit to the day program was on July 29, 2010.

I 222 3510.3 STAFF TRAINING

I 222

Cross Reference W189

6/1/12

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

This Statute is not met as evidenced by:  
Based on observation, interview and record review, the the group home for persons with intellectual disabilities (GHPID) failed to provide ongoing in-service training for staff on gait belt use as recommended to ensure resident's health and safety, for one of three residents in the sample. (Resident #2)

The finding includes:

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	X5 COMPLETE DATE
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On May 9, 2012, at 4:37 p.m., Resident #2 was observed walking from the living room area, to kitchen and back to the living room area with an unsteady gait. The resident appeared to have a blue gait belt on with loops attached to the back of the gait belt. At 4:48 p.m., Resident #2 got up from the dining table and stumbled slightly as he walked to the kitchen to put his plate into the sink independently. At 5:16 p.m., the resident was observed independently walking down the steps from his bedroom to the living room area without his gait belt. Continued observations revealed Resident #2 was observed ambulating independently throughout the remainder of the survey without the use of his gait belt.

Review of Resident #2's physical therapy (PT) assessment dated May 22, 2011, on May 11, 2012, at 11:41 a.m., revealed the resident walked with an unsteady gait. Further review of the assessment revealed that staff supervision was recommended for Resident #2's safety while ambulating. The PT also recommended the use of the gait belt for safety. Continued review of Resident #2's records revealed current physician's orders dated May 2012. According to the orders, the gait belt was to be use while ambulating.

Interview with Staff #2 on May 11, 2012, at approximately 3:30 p.m., revealed that on May 9, 2012, he was responsible for Resident #2 during the 4 PM - 12 AM shift. Further interview with Staff #2 revealed that he did not support the resident with the use of the gait belt while he ambulated each time throughout the evening. When asked, Staff #2 stated that he had received training on the use of Resident #2's gait belt.

The GHPID's staff in-service training record was

Health Regulation & Licensing Administration

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reviewed on May 11, 2012, at approximately 4:00 p.m. There was an agenda that staff members from multiple shifts had been trained on the use of the gait belt for Resident #2. However, there was no signature sheet attached with the agenda indicating what staff had actually received the training.

Interview with the GHPID's qualified Intellectual disabilities professional (QIDP) on May 11, 2012, at 4:17 p.m., revealed that all staff had been trained on the use of Resident #2's gait belt. Further interview revealed that she could not locate the signature sheets for the training on the use of the gait belt.

At the time of the survey, there was no documented evidenced that staff had been trained on the use of Resident #2's gait belt as recommended.