

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: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 January 23, 2013, to January 25, 2013. A sampling of two clients was selected from a population of four women with varying degrees of intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, one guardian, 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 261 483.440(f)(3) PROGRAM MONITORING & CHANGE

W 261

The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure its specially constituted committee included members with no ownership or controlling interest to review an individual's psychotropic medications (Haldol and

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE <i>Courtney A. Reese</i>	TITLE Program Director	(X6) DATE 2/22/13
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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 261	<p>Continued From page 1</p> <p>Clonazepam), for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On January 24, 2013, at 4:10 p.m., interview with the qualified intellectual disabilities professional (QIDP/Staff #1) revealed Client #1 was prescribed medications including Haldol 5 milligrams (mg) daily. She also stated that the psychiatrist prescribed the client Clonazepam on November 21, 2012 for behavior management; however, it was discontinued on January 14, 2013. Further discussion with the QIDP/Staff #1 revealed that the facility utilizes a specially constituted committee entitled the Human Rights and Restrictive Controls Committee (HRRCC) to 'review and monitor the use of psychotropic medications.</p> <p>Review of the corresponding HRRCC records on January 25, 2013, at 9:03 a.m., revealed a telephonic meeting was held on November 21, 2012. According to the documentation of the meeting, the participants included the HRRCC chairperson and four other agency staff (the HRRCC secretary, the facility's QIDP/Staff #1, an agency registered nurse (RN), and two other persons whom the QIDP/Staff #1 identified as QIDPs within the agency). The QIDP/Staff #1 was asked on January 25, 2013, at approximately 10:35 a.m., if the community representatives were involved with the review of the medications. The QIDP/Staff #1 revealed that no community representative was included in aforementioned telephonic meeting.</p> <p>At the time of the survey, the facility failed to</p>	W 261	<p>On 2/4/13 the Human Rights Committee convened a meeting which included a community representative participant. At this meeting the nature of this deficiency was discussed and a revised policy to include approval by Committee Members in the event of telephone approvals for Human Rights Issues. The Community Representative will be contacted for a review and the approval will be included in the committee minutes. This revised policy will be effective following a final review at the next meeting on 3/4/13. The QIDP will ensure that the Community Representative is included in all telephone conferences and approvals.</p>	3/4/13

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W 261	Continued From page 2 ensure that its HRRCC meetings included members with no ownership or controlling interest in the agency. It should be noted that on December 3, 2012, the HRRCC convened again. At that time, the appropriate membership was present, but there was no evidence that the client's medications were reviewed.	W 261		
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's nursing services failed to ensure one of four clients residing in the facility received a medication as prescribed. (Client #3) The finding includes: The facility's nursing services failed to timely report a drug irregularity to the primary care physician (PCP). Observation during the medication administration on January 23, 2013, at 8:17 a.m., revealed Client #3's Clonazepam .5 milligram tablet was not available as prescribed. At 8:22 a.m., licensed practical nurse (LPN) #3 telephoned the director of nursing (DON) for further instructions. Interview with LPN #3 on January 23, 2013, at 8:22 a.m., revealed the pharmacy did not deliver Client #3's prescribed Clonazepam .5 milligram (mg.) tablets to the facility. LPN #3 then	W 331		

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w 331	<p>Continued From page 3</p> <p>presented a medication bubble pack with Client #1's name on it, which contained Clonazepam 1 mg. tablets. LPN #3 revealed that earlier in the week, the DON instructed the nurses to split the Clonazepam 1 mg tablet equally into two parts until the pharmacy delivered Client #3's medication. Interview with LPN #1 on January 23, 2013, at 6:53 p.m. provided the same information. During further discussion with both LPN #3 and #1, it was acknowledged that on January 21, and January 22, 2013 they had administered Client #3 Clonazepam as instructed by the DON.</p> <p>Interview with the DON on January 23, 2013, at 8:22 a.m., confirmed that Client #3's prescribed Clonazepam .5 mg was not delivered as required. She also stated that the pharmacy does not deliver on weekends and holidays, but it was expected later that day. Continued discussion with the DON revealed that during the interim, she instructed the LPNs to administer Client #3 Clonazepam in the aforementioned manner. The DON indicated that the PCP was not informed that Clonazepam .5 mg was not available for Client #3 until the morning of January 23, 2013. According to the DON, the PCP then instructed her to wait for the Clonazepam .5 mg delivery 1 from the pharmacy, before administering additional dosages in the home.</p> <p>Record review on January 23, 2013, at 9:35 a.m., revealed Client #3 had a current physician's order for Clonazepam .5 mg by mouth three times a day. According to the medication administration record (MAR), the client receives Clonazepam .5 mg at 8:00 a.m., 12:00 noon and 7:00 p.m.</p>	W 331		
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W 331	Continued From page 4 At the time of the survey, however, there was no evidence the PCP was notified timely for further directions, after the pharmacy did not deliver Client #3's medication.	W 331	The PCP will be notified immediately by the DON to receive instructions for directions whenever medications have not arrived from the pharmacy. All nursing staff will review policy and procedures for Medication Administration and Physician Orders.	2/28/13
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Health Regulation & Licensing Administration

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1000⁰¹ INITIAL COMMENTS

1000

A licensure survey was conducted from January 23, 2013 to January 25, 2013. A sampling of two residents was selected from a population of four women with varying degrees of intellectual and developmental disabilities.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, one guardian, 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.]

10901 3504.1 HOUSEKEEPING

1090

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

This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHID) failed to ensure that the interior and exterior of the facility were maintained in a safe and orderly manner for four of four residents in the facility. Residents #1, #2, #3, and #4)

The findings include:

On January 25, 2012, beginning at 10:32 a.m., the Qualified Intellectual Disabilities Professional (Staff #1) accompanied the surveyor through the

Health Regulation & Licensing Administration

Constantine A. Reese Program Director

TITLE

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

(X6) DATE

2/22/13

STATE FORM

5E25

YZS211

If continuation sheet of 7

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I 090	<p>Continued From page 1</p> <p>facility's environment to conduct observations.</p> <p>The following concerns were identified:</p> <p>A. The facility failed to maintain the exterior environment.</p> <ol style="list-style-type: none"> The dryer vent located on the outside of the facility lacked louvers or a cover. All of the balusters were missing from the right railing beside the steps leading from the back porch to the ground. The fence installed on the right side of the house was disconnected from the gate post. This permitted the ends of the nails which previously attached the fence to the post to be exposed. Cold air was entering the basement door around the edges. Closer observation of the door revealed no caulking or other measure was used to prevent the cold air from entering the facility at the edges of the door. <p>At the time of the survey, there was no evidence the facility's exterior was maintained in a manner to ensure the environmental needs of the individuals were addressed.</p> <p>B. The facility failed to maintain the interior environment.</p> <ol style="list-style-type: none"> The cover was missing from the ceiling light fixture at the top of the stairs, leading from the first floor to the basement. The ventilation fan installed in the ceiling of the bathroom located on the first floor was very noisy when turned to the on position, There was an 	I090	<p><u>Exterior</u></p> <ol style="list-style-type: none"> The dryer vent located on the outside of the facility was repaired with a cover. 1/31/13 Railing beside the steps leading from the back porch will be repaired to include missing balusters. 3/8/13 The fence on the right side of the house will be repaired to connect the gate post. 3/8/13 The basement door will be repaired to prevent cold air from entering the facility. 3/8/13 <p><u>Interior</u></p> <ol style="list-style-type: none"> A new cover will be placed on the ceiling light fixture at the top of the stairs. 1/31/13 The ventilation fan in hallway bathroom will be cleared of dust and repaired. 3/8/13 Light bulb will be replaced in the light fixture located over the hand sink. 1/31/13

Health Regulation & Licensing Administration

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I 090	Continued From page 2 accumulation of dust on the vent covering the ceiling fan. Additionally, the light fixture installed adjacent to the ceiling heat unit in the bathroom was not operable. 3. One of the three sockets in the light fixture located above the hand sink in the bathroom on the main level of the facility contained an inoperable light bulb. 4. Scalling paint was observed on the surface of the tub in the bathroom located on the main level of the facility. 5. The door knob was very loose on the door which exited from the bedroom of Residents #1 and #3 to the exterior of the facility. 6. The wall plate was broken on the electrical outlet, located beside the arm chair, in the sitting room of the basement. T Water was observed to remain in the hand sink after the drain was turned to an open position, in the master bathroom located in the bedroom of I Residents #1 and #3. 8. Three knobs were observed to be missing from Resident #4's chest of drawers. One of the door knobs was also missing from the closet door. Interview with the Staff #1 revealed that Resident # 4 removes the knobs from her furniture and that they had been previously replaced. 10. The lamp located on Resident #4's dresser lacked a light bulb, Further observation revealed it was not connected to an electrical outlet.	I 090	4. Bathtub in hallway bathroom will be resurfaced. 5. The doorknob will be repaired on the exit door of bedroom of resident #1 and #3. 6. The wall plate will be replaced to the electrical outlet in basement sitting room. 7. Drain will be cleared in hand sink in bathroom of resident #1 and #3. 8. Three knobs will be replaced for the dresser drawers in resident #4's bedroom. 9. The door knob will be replaced to closet door in resident #4's bedroom. 10. Lightbulb will be replaced in lamp in resident #4's bedroom.	3/8/13 1/31/13 1/31/13 1/31/13 2/22/13 2/11/13 1/31/13
I 206	3509.6 PERSONNEL POLICIES	I 206		

Health Regulation & Licensing Administration

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i206	Continued From page 3 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 individuals with intellectual disabilities (GHID) failed to ensure that all employees and health care professionals had current health certificates on file, for 1 of 10 direct support staff (Staff #3), 2 of 9 licensed practical nurses. (LPN #1 and #2), 1 of 5 consultants (Consultant #1) and the primary care physician. The findings include: On January 24, 2013, beginning at 3:40 p.m., review of the personnel records for all employees, including licensed professionals revealed the following: 1. There was no evidence of a current physician's health inventory/certificate for LPN #1 and LPN #2. 2. There was no evidence of a complete physician's health inventory/certificate for Staff #3 and the pharmacist (Consultant #1). 3. There was no evidence of a physician's health inventory/certificate for the primary care physician. interview with Staff #1 on January 25, 2013, at	i 206	1.A current health certificate was obtained for LPN #1 and LPN #2 2/8/13 2.A current health certificate will be obtained for staff #3 and the pharmacist. 2/28/13 3.A current health certificate will be obtained for Primary Care Physician. 2/28/13

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1 2061	Continued From page 4 approximately 10:00 a.m.. revealed she will retrieve the aforementioned documents from the human resource director.	1 206		
1 401	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 observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID), failed to ensure one of four clients residing in the facility received medication as prescribed . (Client #3) The finding includes: The facility's nursing services failed to timely report a drug irregularity to the primary care physician. (PCP). Observation during the medication administration on January 23, 2013, at 8:17 a.m. revealed Resident #3's Clonazepam .5 milligram tablet was not available as prescribed. At 8:22 a.m., licensed practical nurse (LPN) #3 telephoned the director of nursing (DON) for further instructions. Interview with LPN #3 on January 23, 2013, at 8:22 a.m.. revealed the pharmacy did not deliver Resident #3's prescribed Clonazepam .5 milligram (mg.) tablets to the facility. LPN #3 then presented a medication bubble pack with Resident #1's name on it, which contained	1 401	Cross-reference W331	2/28/13

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1401	<p>Continued From page 5</p> <p>Clonazepam 1 mg, tablets. LPN #3 revealed that earlier in the week, the DON instructed the nurses to split the Clonazepam 1 mg tablet equally into two parts until the pharmacy delivered Resident #3's medication. Interview with LPN #1 on January 23, 2013, at 6:53 p.m. provided the same information. During further discussion with both LPN #3 and #1, it was acknowledged that on January 21, and January 22, 2013, they had administered Resident #3 Clonazepam as instructed by the DON.</p> <p>Interview with the DON on January 23, 2013, at 8:22 a.m., confirmed that Resident #3's prescribed Clonazepam .5 mg was not delivered as required. She also stated that the pharmacy does not deliver on weekends and holidays, but it was expected later that day. Continued discussion with the DON revealed that during the interim, she instructed the LPNs to administer Resident #3 Clonazepam in the aforementioned manner. The DON indicated that the PCP was not informed that Clonazepam .5 mg was not available for Resident #3 until the morning of January 23, 2013. According to the DON, the PCP then instructed her to wait for the Clonazepam .5 mg delivery from the pharmacy, before administering additional dosages in the home.</p> <p>Record review on January 23, 2013, at 9:35 a.m., revealed Resident #3 had a current physician's order for Clonazepam .5 mg by mouth three times a day. According to the medication administration record (MAR), the resident receives Clonazepam .5 mg at 8:00 a.m., 12:00 noon and 7:00 p.m.</p> <p>At the time of the survey, however, there was no evidence the PCP was notified timely for further</p>	1401	

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	1401 ' Continued From page 6 directions, after the pharmacy did not delivery Resident #3's medication.	1401		
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