

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

PRINTED: 01/07/2014  
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  12/04/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		
(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	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from December 2, 2013, through December 4, 2013. A sample of two clients was selected from a population of four clients with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews, and the review of records, including incident reports.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Clinical Director (CD) Chief Operating Officer (COO) Director of Nursing (DON) Direct Support Professional (DSP) Group Home for Individuals with Intellectual Disabilities (GHIID) Intermediate Care Facility (ICF) Incident Management Coordinator (IMC) Individual Support Plan (ISP) Individualized Program Plan (IPP) Licensed Practical Nurse (LPN) Physical Therapist (PT) Qualified Intellectual Disabilities Professional (QIDP) Registered Nurse (RN) Emergency Room (ER) Behavior Support Plan (BSP) Crisis Prevention Institute (CPI)</p>	W 000			
W 252	<p><b>483.440(e)(1) PROGRAM DOCUMENTATION</b></p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable</p>	W 252			

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

(TITLE)

(X6) DATE

*Constance A. Reese* *Program Director* *1/14/14*

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 252	<p>Continued From page 1 terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the data collection was maintained at the frequency required by the BSP for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On December 2, 2013, at 5:29 p.m., while eating dinner, Client #2 quickly threw her spoon approximately five feet to the opposite end of the table. The spoon traveled through the air and landed on the floor between Client #3 and Staff #3'. After observing that Client #2 had thrown the spoon, her assigned one on one staff instructed her that she should not throw objects.</p> <p>On December 2, 2013, at 5:32 p.m., Staff #8 revealed that Client #2's throwing of objects was sudden, and often could not be anticipated. The staff further stated the client had a BSP which addressed a targeted behavior of physical aggression, which included throwing objects.</p> <p>On December 3, 2013, at 1:14 p.m., review of Client #2's BSP dated August 22, 2013, revealed it included interventions to address a target behavior of physical aggression (pinching, hitting, slapping, throwing objects at others). According to the BSP, the frequency of target behaviors should be recorded as they occur in the home and the day program. Additional data should be recorded on the antecedent-behavior-consequences (ABC) data</p>	W 252			

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W 252	<p>Continued From page 2 collection forms and reviewed at least monthly or more frequently if needed.</p> <p>On December 3, 2013, at 1:08 p.m., review of the data collection form revealed on December 2, 2013 (4:00 p.m. to 12:00 a.m.), staff documented that Client #2 exhibited two incidents of physical aggression and three episodes of verbal aggression. It should be noted however, that there was no ABC data collected to provide the details of the behavioral incidents the client exhibited.</p> <p>Interview with the facility's QIDP on December 3, 2013 at 1:14 p.m., revealed she observed Client #2 throw her spoon across the table during dinner on December 2, 2012. The QIDP confirmed that staff was required to maintain ABC data, in addition to documenting the total daily frequency of each targeted behavior. The QIDP reviewed the data collection for December 2, 2013, and verified that the staff failed to document the ABC data as required.</p> <p>At the time of the survey, the facility failed to ensure that data relative to the accomplishment of Client #2's behavioral objective was consistently maintained at the required frequency for accurate monitoring of progress.</p>	W 252	<p>Client #2's one to one staff will receive additional training on documenting behavioral incidents on the ABC data sheet. QIDP and Residential Manager will monitor weekly to ensure that consistent documentation on the behavioral objective for client #2.</p>	2/28/14	

Health Regulation & Licensing Administration

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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from December 2, 2013, through December 4, 2013. A sample of two residents was selected from a population of four residents with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews, and the review of records, including incident reports.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Clinical Director (CD) Chief Operating Officer (COO) Director of Nursing (DON) Direct Support Professional (DSP) Group Home for Individuals with Intellectual Disabilities (GHID) Intermediate Care Facility (ICF) Incident Management Coordinator (IMC) Individual Support Plan (ISP) Licensed Practical Nurse (LPN) Physical Therapist (PT) Qualified Intellectual Disabilities Professional (QIDP) Registered Nurse (RN) Emergency Room (ER) Behavior Support Plan (BSP) Crisis Prevention Institute (CPI)</p>	I 000		
I 203	<p><b>3509.3 PERSONNEL POLICIES</b></p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the group</p>	I 203		

Health Regulation & Licensing Administration

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

TITLE

(X8) DATE

STATE FORM

6899

E5DB11

If continuation sheet 1 of 5

*Janastance L. Reese*      *Program Director*      1/14/14

Health Regulation & Licensing Administration

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I 203	Continued From page 1  home for persons with intellectual disabilities (GHPID) failed to ensure three (3) of twenty-one (21) staff were provided the opportunity to annually review their written job descriptions as required by this section. (Staff #14,#19, and #21)  The finding includes:  On December 3, 2013, beginning at 11:45 a.m., review of the personnel files revealed the GHPID's failed to provide evidence that the facility had discussed the contents of job descriptions for three of the seven LPNs (Staff #14,#19, and #21).  On December 4, 2013, at approximately 12:24 p.m., an interview with the QIDP and RN who provided the information to complete the personnel review, confirmed the aforementioned findings. /	I 203	The facility's QIDP will review job descriptions for staff #14, #18 and #21. In the future all job descriptions will be reviewed annually for all staff with signature and date.	12/31/13	
I 206	<b>3509.6 PERSONNEL POLICIES</b>  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 hlm or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all employees and health care professionals had current health certificates on file, for 1 of 12 direct support staff (Staff #5 )	I 206			

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I 206	Continued From page 2  and 3 of 10 consultants. (Consultants #3, #9 and #10)  The findings include:  On December 3, 2013, beginning at 9.35 a.m., review of the personnel records for all employees, including professional health consultants and nurses, revealed the following:  1. There was no evidence of a complete physician's health inventory/certificate for Staff #5.  2. There was no evidence of a complete physician's health inventory/certificate for the pharmacist (Consultant #3), the podiatrist (Consultant #9), and the physical therapist (Consultant#10).  3. There was no evidence of a complete physician's health inventory/certificate for one LPN (Staff #16).  On December 4, 2013, at approximately 12.24 p.m., an interview with the QIDP and RN acknowledged the aforementioned findings.	I 206	1. Staff #5 will obtain a current health certificate to be filed in personnel records.  2. Health Certificates will be obtained from Consultant #3, #9 and #10.  3. Health Certificate will be obtained from staff #16. QIDP and Residential Manager will review personnel folders two times yearly for current credentials.	1/31/14  1/31/14  1/31/14  1/31/14
I 229	3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;	I 229		

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I 229	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: The GHPID failed to ensure designated one on one staff were trained on crisis intervention techniques for one of two residents in the sample (Resident #2).</p> <p>The finding includes:</p> <p>On December 2, 2013, at 5:29 p.m., while eating dinner, Resident #2 quickly threw her spoon approximately five feet to the opposite end of the table. The spoon traveled through the air and landed on the floor between Resident #3 and Staff #3. Upon observing that Resident #2 had thrown the spoon, her one on one (Staff #8) instructed the resident that she should not throw objects.</p> <p>On December 2, 2013, at 5:32 p.m., Staff #8 revealed that Resident #2's throwing of objects was sudden, and often could not be anticipated. According to staff, the resident had a BSP which addressed a targeted behavior of physical aggression, which including throwing objects.</p> <p>On December 3, 2014, at 1:14 p.m., interview with the facility's QIDP confirmed that she also observed Resident #2 throw the spoon across the table during dinner on December 2, 2013. The QIDP also revealed that the resident's BSP identified management strategies to address physical aggression. According to the QIDP, if the resident is not redirectable during physical aggression, crisis intervention techniques (physical) may be implemented. Further discussion with the QIDP, however revealed that the direct support staff assigned to Resident #2 were not trained in CPI techniques.</p> <p>On December 3, 2013, at 12:48 p.m., review of</p>	I 229	Cross-reference W252	2/28/14

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I 229	Continued From page 4  Resident #2's BSP dated August 22, 2013, revealed it included interventions to address a target behavior of physical aggression (pinching, hitting, slapping, throwing objects at others). Further review of the BSP confirmed that if the resident had a behavior crisis, staff must follow the crisis procedures as outlined in agency and day program policy. The BSP stated, "...Staff must be trained in non-violent crisis intervention, such as CPI, and MANDT, and prepared to use non-violent crisis strategies, coupled with verbal and physical redirection..."  On December 4, 2013, at 9:39 a.m., review of the provided training records revealed no evidence that staff assigned to implement Resident #2's BSP had been trained on CPI techniques.	I 229	Staff will receive training in MANDT and additional training from the facility's Psychologist on interventions to address target behaviors for client #2.	2/28/14