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.	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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	W 000		
	A recertification survey was conducted from June 6, 2012, through June 8, 2012. A sampling of three clients was selected from a population of six clients with varying degrees of intellectual disabilities. The survey was initiated utilizing the fundamental process. The findings of the survey were based on observations, interviews with one client, staff in the home and at three day programs, as well as a review of the 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.]		Reiewd 7/6/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	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, staff interview and record verification, the qualified intellectual disabilities professional (QIDP) failed to coordinate, integrate, and monitor services, for one of three clients in the sample. (Client #3) The findings include: The QIDP (Staff #5) failed to coordinate services to ensure Client #3 had white hyper allergenic gloves to prevent her from picking her skin.		1. Several pairs of white hyper-allergenic gloves will be purchased for Client #3. Primary Care Nurse will provide training for staff on the usage of the gloves. Usage and documentation will be monitored by the QIDP.	7/5/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtney A. Reese TITLE: Program Director (X6) DATE: 7/6/12

(X4) ID PREFIX TAG: W 000 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.

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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 159	Continued From page 1 Observation during the medication administration on June 6, 2012, at 5:54 p.m., revealed the licensed practical nurse (LPN #1) applied Bactroban to the open sores on Client #3's arms and legs. Interview with LPN #1 at the same time, revealed the client picks and scratches her skin. On June 8, 2012, at 1:47 p.m., review of a dermatology consultation report dated August 22, 2011, revealed Client #3's nails should be kept short, and to either cover her hands with gloves or duct tape at night to prevent her from picking her skin. On June 8, 2012, at 3:00 p.m., review of the human rights committee minutes dated July 11, 2011, revealed that Client #3 was approved to wear white hyper allergenic gloves to prevent skin-picking. Interview with the QIDP (Staff #5) on June 8, 2012, at 1:45 p.m., revealed that Client #3 only needs to wear the gloves at night, if she picks her skin. Interview with one to one support (Staff #3) on June 8, 2012, at 4:15 p.m., revealed verbal redirection and gloves are used when the client picks her skin. When the surveyor requested to see the client's gloves, the one to one support staff went to get the gloves. A few minutes later, the staff returned with two black outdoor type winter gloves, stating there were no white hyper allergenic gloves available for the client. Further interview at approximately 4:20 p.m., with the one to one (Staff #3) revealed she was not able to locate the white gloves. At the time of the survey, there was no evidence the QIDP (Staff #5) coordinated services to ensure white hyper allergenic gloves were available for Client #3 to be used as	W 159		

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER
COMMUNITY MULTI SERVICES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
703 RANDOLPH STREET NW
WASHINGTON, DC 20011

(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 159	Continued From page 2 recommended.	W 159		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff demonstrated competency to address the needs of the clients, for one of three clients in the sample. (Client #3) The findings include: The facility failed to ensure that the one to one staff were trained effectively on documenting health concern's for Client #3. On June 6, 2012, at 3:57 p.m., Client #3 pointed to her mouth and told her one to one (Staff #3) that her mouth hurts. The one to one staff looked at her mouth and stated, "It's not red". At approximately 5:20 p.m., licensed practical nurse (LPN) #1 entered the facility to administer medications to the clients; but the one to one (Staff #3) failed to inform the LPN of Client #3's aforementioned complaint. On June 7, 2012, beginning at 1:00 p.m., review of the LPNs' notes failed to reveal that Client #3 complained that her mouth was hurting on June 6, 2012. Interview with the Staff #3 on June 8, 2012, at 4:17 p.m., revealed that she "mentioned" Client	W 192	One-to-One staff for Client #3 will receive training from the Primary Care Nurse on reporting and documenting health concerns to Nursing Staff.	7/16/12

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	(X2) MULTIPLE CONSTRUCTION A BUILDING ____ B WING ____	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	x5 COMPLETION DATE
W 192	Continued From page 3 #3's complaint of mouth pain to the next staff (Staff #4), but did not inform LPN #1. Further interview with the staff revealed that she was required to inform the next staff and document the complaint on a health concern form to be submitted to the LPN, however had failed to do so. Interview with LPN #1 and the primary registered nurse (RN #1) on June 8, 2012., at 4:30 p.m. revealed that staff had not notified them of the client's complaint of mouth pain. Review of the facility's in-service training records on June 8, 2012, at 3:30 p.m., revealed that staff had received training on documenting health concerns on May 28, 2010.	W 192		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health for one of three clients in the sample. (Client #3) The findings include: 1. The facility failed to address Client #3's complaint of mouth pain.	W 356	A dental appointment has been scheduled for Client #3 to address her complaint of mouth pain and for the recommended x-rays to determine the extent of her periodontal disease.	7/16/12

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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 356 Continued From page 4

W 356

On June 6, 2012, at 3:57 p.m., Client #3 pointed to her mouth and told her one to one direct support (Staff #3) that her mouth hurt. Staff #3 looked at the exterior of the client's mouth and stated "It's not red. " At approximately 5:20 p.m., the licensed practical nurse (LPN #1) entered the facility to administer medications to the clients. However, the one to one direct support (Staff #3) was not observed to inform LPN #1 of Client #3's complaint of mouth pain.

Interview with the facility's primary registered nurse (RN #1) on June 8, 2012, at 2:49 p.m., revealed that staff had not reported Client #3's complaint of mouth pain on June 6, 2012, to the nurse. Interview with the Staff #3 on June 8, 2012, at 4:17 p.m., revealed that she "mentioned" Client #3's complaint to the next staff, but did not inform the LPN. Further interview with the Staff #3 revealed that she was required to inform the next staff and document the complaint on a health concern form to be submitted to the LPN, however had failed to do so.

Review of Client #3's record on June 8, 2012, at 2:32 p.m., additionally failed to provide evidence that the complaint had been documented.

At the time of the survey, the facility failed to ensure Client #3 was assessed to determine a possible cause of her mouth pain.

2. The facility failed to ensure Client #3 received recommended x-rays timely to determine the extent of her periodontal disease.

Review of Client #3's dental records on June 8, 2012, at 3:08 p.m., revealed a consultation report

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:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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 356 Continued From page 5 W 356

dated November 11, 2010 that stated a panoramic x-ray of the client's teeth was attempted, however, the client refused to cooperate. The dentist continued to recommend that the panoramic x-ray be performed. Further review of Client #3's record revealed she was seen by the dentist on March 2, 2011 for a periodontal and scaling appointment. On that date, the dentist diagnosed the client with generalized gingivitis, moderate to heavy calculus and plaque, and caries, and recommended full mouth radiographs. Further review of Client #3's record revealed that the recommended x-rays (November 11, 2010 - panoramic x-ray and March 2, 2011 - full mouth radiograph), were not completed until October 13, 2011 (11 months after the recommendation.).

Interview with the director of nursing (RN #2) on June 8, 2012, at 4:17 p.m., revealed that Resident #3 had a history of advanced periodontal disease and that on October 13, 2012, multiple teeth were extracted.

At the time of the survey, the facility failed to ensure Client #3 received timely dental services.

W 436 483.470(g)(2) SPACE AND EQUIPMENT W 436

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER: COMMUNITY MULTI SERVICES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 703 RANDOLPH STREET NW, WASHINGTON, DC 20011

(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 436	Continued From page 6 Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment was furnished, monitored and maintained as recommended, for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. Observation during the medication administration on June 6, 2012, at 5:54 p.m., revealed licensed practical nurse (LPN #1) applied Bactroban to the open sores on Client #3's arms and legs. Interview with LPN #1 at the same time, revealed the client picks and scratches her skin. Record review on June 8, 2012, at 1:47 p.m., revealed a dermatology consultation report dated August 22, 2011. The dermatologist recommended to keep nails short and to either put on restraints at night, or cover her hands with gloves, or with duct tape at night. However, on June 8, 2012, at 3:00 p.m., review of the human rights minutes dated July 11, 2011, revealed the committee approved white hyper allergenic gloves to prevent Client #3 from picking her skin. Interview with the qualified intellectual disabilities professional (Staff #5) on June 8, 2012, at 1:45 p.m., revealed that Client #3 only needs to wear the gloves at night if she picks her skin. Interview with one to one support Staff #3 on June 8, 2012, at 4:15 p.m., revealed verbal redirection and gloves are used when the client picks her skin. When the surveyor requested to see the client's gloves, the one to one support staff (Staff #3) went to get the gloves. A few minutes later, the staff returned with two black outdoor type winter	W 436	Cross reference W159	7/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEFUSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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 436	Continued From page 7 gloves. Further interview at approximately 4:20 p.m., with Staff #3 revealed she was not able to locate the white gloves. At the time of the survey, there was no evidence the QIDP (Staff #5) coordinated services to ensure white hyper allergenic gloves were available for Client #3 to be used as recommended. At the time of the survey, the facility failed to furnish Client #3's with white hyper-allergenic gloves as recommended to prevent skin picking. 2. The facility failed to ensure Client #1 was provided a gait belt timely, as evidenced below: On June 6, 2012, at 5:47 p.m., Client #1 was observed wearing a gait belt, as she walked down the steps from the second floor holding onto the railing. The gait belt was observed to have an unsecured loop. On June 6 2012, at 6:02 p.m., the review of unusual incidents revealed on February 3, 2012, Client #1 fell at her day program and fractured her right elbow. Record review on June 7, 2012, at 4:32 p.m., revealed on February 24, 2012, the physical therapist (PT) recommended a gait belt to ensure the client's safety during ambulation. Record review on June 7, 2012, at 4:35 p.m., revealed a sales order, dated April 24, 2012, to purchase a padded gait belt for the client. The subsequent QIDP progress note, dated May 12, 2012, revealed the gait belt was scheduled to be delivered on May 2, 2012, approximately two months after the training. On June 7, 2012, at 4:30 p.m., the QIDP (Staff	W 436	1. Several pairs of white hyper-allergenic gloves will be purchased for Client #3. 2. A new gait belt was purchased for Client #1. Director of Nursing will be notified within 24 hrs. whenever adaptive equipment is in disrepair. QIDP will monitor daily for correct usage.	7/5/12 6/10/12

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: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011	

(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 436 Continued From page 8 #5) acknowledged that group home staff reported having observed the loop to be broken on May 31, 2012, when Client #1 was picked up from her day program. On June 8, 2012, at 4:40 p.m., the director of nursing (RN #2) revealed she was working on getting the client a new gait belt, checked the gait belt, and indicated the client should be able to continue to wear her current gait belt until the new gait belt was obtained. At the time of the survey, however, the facility had failed to ensure Client #1 was provided the initial gait belt timely and that it was maintained in good repair.	W 436		

PRINTED: 06/26/2012
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0085		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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
I 000	INITIAL COMMENTS A licensure survey was conducted from June 6, 2012, through June 8, 2012. A sampling of three residents was selected from a population of six residents with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with one client, staff in the home and at three day programs, as well as a review of the 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.]	I 000		
I 090	3504.1 HOUSEKEEPING 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 facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in a safe and orderly manner for six of six residents in the facility. (Residents #1, #2, #3, #4, #5,and #6) The findings include: On June 8, 2012, at approximately 9:20 a.m., the qualified intellectual disabilities professional (QIDP) accompanied the surveyor through the facility to conduct environmental observations.	I 090		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X5 COMPLETE DATE
I090	Continued From page 1	I090		
	The following concerns were identified: 1. The living room sofa was observed to have brown stains from spills. 2. One of three dining room chairs had torn seat cushions. 3. In the basement, there were dark brown stains on the carpet from spills. 4. On the second floor, in the common bathroom, the ceramic tiles were broken on the wall at the front of the bathtub. 5. In Resident #3's bedroom, the Venetian blinds at the window had broken blades. 6. In the basement bathroom, the protective molding on the radiator cover was broken off. This permitted the edge of the metal screen to be exposed, which created the potential for injury.		1. The living room sofa will be clean to remove stains. 2. A new dining room chair will be purchased. 3. Basement carpet will be cleaned or removed to remove stains. 4. Ceramic tiles on the wall at the front of the bathtub will be replaced in the 2nd floor bathroom. 5. Venetian blinds in Client #3's bedroom will be replaced. 6. The protective molding on the radiator in basement bathroom will be repaired.	7/16/12 7/16/12 7/16/12 7/16/12 7/16/12 7/16/12
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, staff interview and record verification, the the group home for persons with intellectual disabilities (GHPID) failed to to ensure the qualified intellectual disabilities professional (QIDP) coordinated, integrated, and monitored services, for one of three residents in the sample. (Resident#3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
1180	Continued From page 2	1180		
	The findings include:			
	The QIDP (Staff #5) failed to coordinate services to ensure Resident #3 had white hyper allergenic gloves to prevent her from picking her skin.		Cross reference W159	7/5/12
	Observation during the medication administration on June 6, 2012, at 5:54 p.m., revealed the licensed practical nurse (LPN #1) applied Bactroban to the open sores on Resident #3's arms and legs. Interview with LPN #1 at the same time, revealed the resident picks and scratches her skin.			
	On June 8, 2012, at 1:47 p.m., review of a dermatology consultation report dated August 22, 2011, revealed Resident #3's nails should be kept short, and to either cover her hands with gloves or duct tape at night to prevent her from picking her skin. On June 8, 2012, at 3:00 p.m., review of the human rights committee minutes dated July 11, 2011, revealed that Resident #3 was approved to wear white hyper allergenic gloves to prevent skin-picking.			
	Interview with the QIDP (Staff #5) on June 8, 2012, at 1:45 p.m., revealed that Resident #3 only needs to wear the gloves at night, if she picks her skin. Interview with one to one support (Staff #3) on June 8, 2012, at 4:15 p.m., revealed verbal redirection and gloves are used when the resident picks her skin. When the surveyor requested to see the resident's gloves, the one to one support staff went to get the gloves. A few minutes later, the staff returned with two black outdoor type winter gloves, stating there were no white hyper allergenic gloves available for the resident. Further interview at approximately 4:20 p.m., with the one to one (Staff #3) revealed she			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
1180	Continued From page 3	1180		
	was not able to locate the white gloves.			
	At the time of the survey, there was no evidence the QI DP (Staff #5) coordinated services to ensure white hyper allergenic gloves were available for Resident #3 to be used as recommended.			
I 222	3510.3 STAFF TRAINING	I 222		
	There shall be continuous, ongoing in-service training programs scheduled for all personnel.		Cross reference W192	7/16/12
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) facility failed to ensure staff received ongoing training to address the needs of resident, for one of three residents in the sample. (Resident#3)			
	The findings include:			
	The facility failed to ensure that the one to one staff were trained effectively on documenting health concern's for Resident #3.			
	On June 6, 2012, at 3:57 p.m., Resident #3 pointed to her mouth and told her one to one (Staff #3) that her mouth hurts. The one to one staff looked at her mouth and stated, "It's not red". At approximately 5:20 p.m., licensed practical nurse (LPN) #1 entered the facility to administer medications to the residents; but the one to one (Staff #3) failed to inform the LPN of Resident #3's aforementioned complaint.			
	On June 7, 2012, beginning at 1:00 p.m., review of the LPNs' notes failed to reveal that Resident #3 complained that her mouth was hurting on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0085		06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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
I 222	Continued From page 4 June 6, 2012. Interview with the Staff #3 on June 8, 2012, at 4:17 p.m., revealed that she "mentioned" Resident #3's complaint of mouth pain to the next staff (Staff #4), but did not inform LPN #1. Further interview with the staff revealed that she was required to inform the next staff and document the complaint on a health concern form to be submitted to the LPN, however had failed to do so. Interview with LPN #1 and the primary registered nurse (RN #1) on June 8, 2012., at 4:30 p.m. revealed that staff had not notified them of the resident's complaint of mouth pain. Review of the facility's in-service training records on June 8, 2012, at 3:30 p.m., revealed that staff had received training on documenting health concerns on May 28, 2010.	I 222		
1401	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, staff interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services, were provided in accordance with the dental health needs for one of three residents in the sample. (Resident #3) The finding includes:	1401	Cross reference W356	7/16/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
I 401	Continued From page 5 1. The facility failed to address Resident #3's complaint of mouth pain. On June 6, 2012, at 3:57 p.m., Resident #3 pointed to her mouth and told her one to one direct support (Staff #3) that her mouth hurt. Staff #3 looked at the exterior of the resident's mouth and stated "It's not red. " At approximately 5:20 p.m., the licensed practical nurse (LPN #1) entered the facility to administer medications to the residents. However, the one to one direct support (Staff #3) was not observed to inform LPN #1 of Resident #3's complaint of mouth pain. Interview with the facility's primary registered nurse (RN #1) on June 8, 2012, at 2:49 p.m., revealed that staff had not reported Resident #3's complaint of mouth pain on June 6, 2012, to the nurse. Interview with the Staff #3 on June 8, 2012, at 4:17 p.m., revealed that she "mentioned" Resident #3's complaint to the next staff, but did not inform the LPN. Further interview with the Staff #3 revealed that she was required to inform the next staff and document the complaint on a health concern form to be submitted to the LPN, however had failed to do so. Review of Resident #3's record on June 8, 2012, at 2:32 p.m., additionally failed to provide evidence that the complaint had been documented. At the time of the survey, the facility failed to ensure Resident #3 was assessed to determine a possible cause of her mouth pain. 2. The facility failed to ensure Resident #3 received recommended x-rays timely to determine the extent of her periodontal disease.	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
I 401	Continued From page 6	I401		

Review of Resident #3's dental records on June 8, 2012, at 3:08 p.m., revealed a consultation report dated November 11, 2010 that stated a panoramic x-ray of the resident's teeth was attempted, however, the resident refused to cooperate. The dentist continued to recommend that the panoramic x-ray be performed. Further review of Resident #3's record revealed she was seen by the dentist on March 2, 2011 for a periodontal and scaling appointment. On that date, the dentist diagnosed the resident with generalized gingivitis, moderate to heavy calculus and plaque, and caries, and recommended full mouth radiographs. Further review of Resident #3's record revealed that the recommended x-rays (November 11, 2010 - panoramic x-ray and March 2, 2011 - full mouth radiograph), were not completed until October 13, 2011 (11 months atfer the recommendation.).

Interview with the director of nursing (RN #2) on June 8, 2012, at 4:17 p.m., revealed that Resident #3 had a history of advanced periodontal disease and that on October 13, 2012, multiple teeth were extracted.

At the time of the survey, the facility failed to ensure Resident #3 received timely dental services.

1420; 3521.1 HABILITATION AND TRAINING 1420

Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.

This Statute is not met as evidenced by:

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
I 420	Continued From page 7	I 420		
	Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning, for one of three residents in the sample. (Resident #3) The findings include: Observation during the medication administration on June 6, 2012, at 5:54 p.m., revealed licensed practical nurse (LPN #1) applied Bactroban to the open sores on Resident #3's arms and legs. Interview with the LPN #1 at the same time, revealed the resident picks and scratches her skin. Record review on June 8, 2012, at 1:47 p.m., revealed a dermatology consultation report dated August 22, 2011. The dermatologist recommended to keep nails short and to either put on restraints at night, or cover her hands with gloves, or with duct tape at night. However, on June 8, 2012, at 3:00 p.m., review of the human rights minutes dated July 11, 2011, revealed the committee approved white hyper allergenic gloves to prevent Resident #3 from picking her skin. Further record review on June 8, 2012, at 3:58 p.m., revealed Resident #3's psychiatric assessment dated June 9, 2011, noted "She is frequently using gloves and bandages in order to keep her body parts safe from self-inflicted wounds." The annual psychological assessment dated October 12, 2011, stated that Resident # 3		Cross reference W159	7/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0085		06/08/2012
NAME OF PROVIDER OR SUPPLIER: COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY STATE, ZIP CODE: 703 RANDOLPH STREET NW WASHINGTON, DC 20011		

(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
I420	Continued From page 8 "was noted to resist with significant amount of force and to make persistent verbal refusals to wear protective gloves to prevent scratching...She has continued to pick and scratch at her face, resulting in injury and continues to pick at her hands, resulting in injury... She is currently wearing gloves. I Interview with the qualified intellectual disabilities professional (Staff #5) on June 8, 2012, at 1:45 p.m., revealed that Resident #3 only needs to wear the gloves at night if she picks her skin. Interview with the one to one support staff (Staff #3) on June 8, 2012, at 4:15 p.m., revealed verbal redirection and white gloves are used when Resident #3 is picking her skin. Further interview with one to one (Staff #3) at approximately 4:20 p.m., revealed that she was not able to locate the white gloves. At the time of the survey, the facility failed to furnished Resident #3's white gloves as recommended for the resident to prevent skin picking.	I420		