

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

PRINTED: 12/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019
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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

A recertification survey was conducted from November 29, 2011 through December 1, 2011. A sample of two clients was selected from a population of two men and two women with various intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations and interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.

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

W 000

Received 12/24/11

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

W 111 483.410(c)(1) CLIENT RECORDS

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure health care records were maintained timely for one of two clients in the sample. (Client #3)

The finding includes:

The facility's nursing services failed to obtain Client #2's x-ray results timely. (Cross reference W331)

Interview with the License Practical Nurse (LPN)

W 111

MTS does have a protocol addressing obtaining medical appointment results in a timely manner and insuring they are reviewed by the required clinical professionals in a timely manner (See: the attached protocol). The protocol was developed in 2008 and nurses and staff that assist individuals supported during medical consultations were trained on its strategies. The protocol will be revised to clearly instruct nurses on how to follow up if they have difficulty obtaining a report...12-30-11
The DON will insure that nurses are retrained on the protocol and that DSPs are retrained on the protocol...1-15-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dette L. Mason, Director of Residential Services</i>	TITLE <i>Director of Residential Services</i>	(X6) DATE 12/23/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency when 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 111	Continued From page 1 on December 1, 2011, at approximately 12:30 p.m., revealed the facility did not have a policy on obtaining medical results and appointments timely.	W 111		12/11/2011
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for one of the two clients in the sample. (Client#2)</p> <p>The finding includes:</p> <p>Observation at the facility on November 29, 2011, at approximately 5:05 p.m., revealed the direct support staff (DSS) prepared Client #2's water with thickener. Further observation revealed the water was prepared to a honey consistency. The DSS then spoon fed the client his water. Interview with the DSS on the same day at approximately 5:15 p.m., confirmed that the water was prepared to a honey consistency.</p> <p>Observations at the day program on November 30, 2011, at 10:16 a.m., revealed the day program staff prepared Client #2's water with thickener. Further observation revealed the water was prepared to a pudding consistency. The day program staff then spoon fed the client his water. Interview with the day program staff on the same day at approximately 10:20 a.m., confirmed the water was prepared to a pudding consistency.</p>	W 120	<p>The QIDP has shared this deficiency with the management staff of the day program who reassured the QIDP that this would be monitored routinely, effective immediately. The QIDP has scheduled a training session for the day program staff on thickening liquids to honey level for Client #2. This training will be implemented...1-17-12.</p>	12/11/2011

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W 120 Continued From page 2

Review of Client #2's physician orders on November 30, 2011, at 1:15 p.m., revealed the client was prescribed a "honey thickened liquids diet".

At the time of the survey the day program staff failed to serve Client #2's water at the prescribed consistency.

W 120

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W 148 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &

The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

W 148

The IMC will conduct a training session with staff to insure that all understand that legal guardians and involved family must be notified about serious reportable incidents involving the individual supported. The QIDP and Facility Manager will attend the training session...12-30-11

The QIDP will insure via incident-by-incident reviews that proper notifications are done and documented...12-23-11

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the client's family members/legal guardians of injuries of unknown origin, for one of two clients included in the sample. (Client #2)

The finding includes:

(Cross Reference W153) On November 30, 2011, at 3:20 p.m., review of a radiology report dated November 19, 2010, revealed Client #2 received an x-ray to the right foot. The result of the x-ray determined that the client had a fractured fifth metatarsal.

Review of the facility's incident report and corresponding investigation on December 1, 2011, beginning at 10:00 a.m., revealed the

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W 148 Continued From page 3
 facility failed to provide evidence that Client #2's legal guardian and/or family members were made aware of the aforementioned incident. Interview with the QIDP on December 1, 2011, at approximately 2:00 p.m., revealed she did not know if the clients' guardian was made aware of the injury to Client #2's right foot.

At the time of the survey, the facility failed to provide evidence that Client #2's legal guardian was made aware of his injury.

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:
 Based on interview and record review, the facility failed to ensure that injuries of unknown origin were reported immediately to the State agency, for one of the two clients included in the sample. (Client #2)

The finding includes:

On November 30, 2011, at 3:20 p.m., review of a radiology report dated November 19, 2010, revealed Client #2 received an x-ray to the right foot. The result of the x-ray determined that the client had a fractured fifth metatarsal.

Interview with the registered nurse (RN) on

W 148

W 153

The Director of Residential Services will meet with the IMC to reinforce the importance of insuring that proper notifications occur to DOH when an incident status changes from reportable to serious reportable. The QIDP and Facility Manager will also receive this feedback from the Director. The new Audit Consultant will monitor compliance on a routine basis...12-30-11

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W 153 Continued From page 4
November 30, 2011, at approximately 3:30 p.m., revealed a direct support staff (DSS) discovered that Client #2's right foot was swollen on October 15, 2010. Upon further evaluation, the facility transported the client to the emergency room on October 16, 2010 and was discharged with a diagnosis of a contusion to the right foot.

Interview with the Incident Management Coordinator (IMC) on December 1, 2011, at 10:08 a.m., revealed that she had opened the investigation on October 20, 2010, and concluded that the client may have injured his foot after hitting it on his wheelchair. The investigation was then closed on October 27, 2010. Further interview with the IMC revealed that months later, it was reported that Client #2's injury (right foot contusion) turned out to be a fracture of the fifth metatarsal. When asked, the IMC stated that she did not notify the department of health (DOH) of the fracture and/or conduct another investigation to determine its cause. The IMC did state however, that she should have done both.

W 153

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 interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) integrated, coordinated and monitored services, for two of the two clients in the sample. (Clients #1 and #2)

W 159

1. The QIDP retrained all staff that support individuals when traveling in company vehicles. Each was retrained on properly locking both sides of a wheelchair and on all other safety elements. Each was asked to demonstrate proper procedures and each was successful...12-1-11

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W 159	Continued From page 5 The findings include: 1. Cross refer to W189. The QIDP failed to ensure that each staff received effective training on wheelchair security and transfer techniques procedures. 2. Cross refer to W120. The QIDP failed to ensure that outside services met the needs of Client #2.	W 159	The QIDP and Facility Manager will monitor compliance at minimum twice weekly...12-15-11 The QIDP retrained all staff on properly assisting Client #2 during transfers and required all staff to demonstrate proper technique. All two-person teams tested where successful...12-1-11 The QIDP and Facility Manager will monitor routine compliance at minimum twice weekly...12-15-11 2. The QIDP has shared this deficiency with the management staff of the day program who reassured the QIDP that this would be monitored routinely, effective immediately. The QIDP has scheduled a training session for the day program staff on thickening liquids to honey level for Client #2. This training will be implemented...1-17-12.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each staff was effectively trained on wheelchair safety as recommended, for one of two clients included in the sample. (Client #2) The findings include: 1. The facility staff failed to ensure that Client #2's wheelchair brakes were secured when placed onto the wheelchair lift, as evidenced below: On November 29, 2011, at 3:34 p.m., Client #2 was observed to be transported from the facility van onto the wheelchair lift by Staff #1. Staff #1 was not observed to secure the wheelchair by locking the client's wheelchair brakes. Staff #1	W 189	1. The QIDP retrained all staff that support individuals when traveling in company vehicles. Each was retrained on properly locking both sides of a wheelchair and on all other safety elements. Each was asked to demonstrate proper procedures and each was successful...12-1-11 The QIDP and Facility Manager will monitor compliance at minimum twice weekly...12-15-11 2. The QIDP retrained all staff on properly assisting Client #2 during transfers and required all staff to demonstrate proper technique. All two-person teams tested where successful...12-1-11 The QIDP and Facility Manager will monitor routine compliance at minimum twice weekly...12-15-11	

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W 189	<p>Continued From page 6</p> <p>was observed to stand on the wheelchair lift behind the client as the wheelchair was lowered to the ground. Continued observations on November 30, 2011, at 4:54 p.m., revealed Staff #2 was not observed to lock Client #2's wheelchair brakes when lowering him down from the wheelchair lift (approximately 2 feet). Staff #2 was observed to stand on the wheelchair lift directly behind the client.</p> <p>Interview with Staff #1 on December 1, 2011, at 9:34 a.m. revealed that she locked the left wheelchair brake when lowering him from the wheelchair lift. Further interview revealed that she should have locked both wheelchair brakes. When asked, Staff #1 stated that she had received recent training on loading clients on and off the van. Interview with Staff #2 on the same day at approximately 4:00 p.m., confirmed that he did not lock Client #2's wheelchair brakes while being lowered to the ground from the wheelchair lift. He also added that he had training on wheelchair security.</p> <p>Review of the in service training records on December 1, 2011, at approximately 11:30 a.m., revealed that all staff had received training on wheelchair security on May 13, 2011. However, at the time of the survey, there was no evidence that training had been effective.</p> <p>2. The facility failed to ensure that Client #2 was transferred from his wheelchair to the sofa chair using the correct transfer techniques, as evidenced below:</p> <p>On November 29, 2011, at 4:27 p.m., evening observations revealed Client #2 was transferred</p>	W 189		
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W 189 Continued From page 7
from his wheelchair to the sofa chair by two staff. Staff transferred the client to the sofa chair by placing their arms underneath the client's arms and legs. At 6:02 p.m. Client #2 was transferred back to his wheelchair from the sofa chair. Staff #3 was observed to support the client by grabbing underneath his arms and legs (just above the knee) and Staff #1 supported the client by grabbing the top of his pants.

Interview with Staff #1 on December 1, 2011, at 9:37 a.m., revealed that she transferred Client #2 from his wheelchair to the sofa chair using two different techniques. Further interview revealed that she was trained to support the client by keeping her back straight and supporting him underneath his arms and legs.

Record review conducted on December 1, 2011, at approximately 12:00 p.m., revealed a document entitled "transfer techniques for Client #2". The document revealed that during the two person transfer, staff should get a firm hold around his [client] upper body (not arms or shoulders).

Review of the in service training records on December 1, 2011, at approximately 12:05 p.m., revealed that all staff had received training on transfer techniques for Client #2 on May 13, 2011. However, at the time of the survey, there was no evidence that training had been effective.

W 189

W 331 483.460(c) NURSING SERVICES
The facility must provide clients with nursing services in accordance with their needs.

W 331

MTS does have a protocol addressing obtaining medical appointment results in a timely manner and insuring they are reviewed by the required clinical professionals in a timely manner (See: the attached protocol). The protocol was developed in 2008 and nurses and staff that assist individuals supported during medical consultations were trained on its strategies. The protocol will be revised to clearly instruct nurses on how to follow up if they have difficulty obtaining a report...12-30-11
The DON will insure that nurses are retrained on the protocol and that DSPs are retrained on the protocol...1-15-12

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W 331 Continued From page 8

This STANDARD is not met as evidenced by:
Based on staff interviews and record review, the facility's nursing staff failed to provide each client with nursing services in accordance with their needs, for one of two clients in the sample. (Client #2)

The finding includes:

The facility's nursing services failed to obtain Client #2's x-ray results timely.

On November 30, 2011, at 3:20 p.m., review of the medical records revealed that Client #2 received an x-ray of the right foot on November 19, 2010. The x-ray was a follow up from a previous injury that was discovered on October 16, 2010 through an emergency room visit. The results of the x-ray revealed that the client had a fractured fifth metatarsal. Continued medical record review revealed the Registered Nurse (RN) did not obtain the x-ray results until January 19, 2011. The primary care physician (PCP) received the results on January 20, 2011, a day later.

In a telephone interview with the licensed practical nurse (LPN) coordinator and a face to face interview with the RN on December 1, 2011, at 2:15 p.m., the LPN and the RN confirmed that they received the results of the x-ray on January 19, 2011, (2 months after the x-ray was taken). When asked, the LPN stated that she had made several phone calls to retrieve the results, but was not able to produce any evidence of her efforts. She further revealed that through her continued efforts, she discovered that the hospital had Client #2's name in reverse and was

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W 331 W 436	<p>Continued From page 9</p> <p>subsequently able to obtain the needed x-ray.</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure necessary adaptive equipment was maintained in good repair, for one of two clients included in the sample. (Client #2)</p> <p>The findings include:</p> <p>The facility failed to ensure Client #2's adaptive equipment was maintained in good repair, as evidence below:</p> <p>a. On November 29, 2011, at 3:53 p.m., Client #2 was observed with a chest harness while sitting in his custom molded wheelchair. The chest harness was observed to be worn with an approximate three inch (3) tear.</p> <p>Interview with 3 direct care staff (DCS), the house manager (HM), and the qualified intellectual disabilities professional (QIDP) on November 29, 2011 and December 1, 2011, respectively, revealed that they were not aware that Client #2's harness was torn. On December 1, 2011, at approximately 10:40 a.m., review of Client #2's current physical therapy quarterly report revealed</p>	W 331 W 436	<p>a. A new chest harness has been ordered for Client #2 and a spare; they are projected to arrive by...1-7-12</p> <p>The QIDP will audit all adaptive equipment bi-monthly to insure that all needed equipment is maintained in good repair...12-30-11</p> <p>b. Client #2's mattress is fine but the padding on top was sunken. It has been replaced...12-23-11. Client #2's sleeping posture contributes to this occurring and the condition of his mattress and padding will be audited on a weekly basis by the Facility Manager. Issues discovered will be addressed as needed...12-30-11</p>	12/01/2011

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W 436	Continued From page 10 the client used the chest harness for safety. b. On December 1, 2011, at 2:30 p.m., observation during of the environmental walk through revealed Client #2 mattress was sunken in. Interview with the QIDP revealed she was not aware that the client's mattress needed to be replaced.	W 436		
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019
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1 000 INITIAL COMMENTS

1 000

A licensure survey was conducted from November 29, 2011 through December 1, 2011. A sample of two residents was selected from a population of two men and two women with various intellectual disabilities.

The findings of the survey were based on observations and interviews with staff in the facility and at one day program, 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.]

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1 180 3508.1 ADMINISTRATIVE SUPPORT

1 180

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 one of two residents included in the sample. (Resident #2)

The findings include:

1. Cross refer to W189. The QIDP failed to ensure that each staff received effective training on wheelchair security and transfer techniques procedures.

1. The QIDP retrained all staff that support individuals when traveling in company vehicles. Each was retrained on properly locking both sides of a wheelchair and on all other safety elements. Each was asked to demonstrate proper procedures and each was successful...12-1-11

The QIDP and Facility Manager will monitor compliance at minimum twice weekly...12-15-11

2. The QIDP retrained all staff on properly assisting Client #2 during transfers and required all staff to demonstrate proper technique. All two-person teams tested where successful...12-1-11

The QIDP and Facility Manager will monitor routine compliance at minimum twice weekly...12-15-11

Health Regulation & Licensing Administration

Debbie H. Moore, Director of Residential Services 12/23/11

(X6) DATE

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

STATE FORM

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If continuation sheet 1 of 8

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180	Continued From page 1 2. Cross refer to W120. The QIDP failed to ensure that outside services met the needs of Resident #2.	180	
206	3509.6 PERSONNEL POLICIES 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 persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for nine of the twelve consultants. (Consultants #2, #3, #4, #5, #8, #9, #10, #11, and #12) The findings include: On December 1, 2011, beginning at 1:01 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for consultants #2, #3, #4, #5, #8, #9, #10, #11, and #12. At approximately 3:20 p.m., on the same day, interview with the qualified intellectual disabilities professional acknowledged that there was no evidence of health inventories performed by a physician for the aforementioned personnel.	206	MTS has audited all personnel files including those mentioned in this citation. Clinicians and staff with deficiencies have been notified and given until 12-30-11 to submit the needed updates...12-30-11 Henceforth, personnel files will be audited on a routine quarterly basis and staff and clinical consultants will be proactively notified to submit needed updates. HR will track compliance and implement appropriate follow up steps as needed...1-15-12

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1227	Continued From page 2	1227	
1227	3510.5(d) STAFF TRAINING	1227	
	<p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR) and first aid, for three of twelve employees. (Employees #1, #9, and #12)</p> <p>The finding includes:</p> <p>The GHPID failed to ensure a current first aid and CPR certification was on file for Employees #1, #9, and #12). This was confirmed by the qualified intellectual disabilities professional at approximately 3:25 p.m., on December 1, 2011.</p>		
1271	3513.1(b) ADMINISTRATIVE RECORDS	1271	
	<p>Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:</p> <p>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities</p>		<p>MTS is developing a master consultant file that will maintained at the main office and will travel to the home on the first day of each survey...1-15-12</p>

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1271	<p>Continued From page 3</p> <p>(GHPID) failed to ensure that all the required administrative records were available for review, for five of the twelve consultants providing services.</p> <p>The finding includes:</p> <p>On November 29, 2011, at 1:00 p.m., an entrance conference was conducted with the qualified Intellectual disabilities professional (QIDP). The QIDP agreed to make available for review the personnel records of all employees, including licensed professional health consultants. On December 1, 2011, beginning at 1:01 p.m., review of the personnel records for health care professionals revealed no evidence of a current administrative record for the social worker, speech and language therapist, occupational therapist, registered nurse and the licensed practical nurse. The QIDP said she would follow-up with the agency's main office.</p> <p>On December 1, 2011, at approximately 4:00 p.m., an exit conference was conducted with the administrative staff to discuss the outcome of the survey. It was at this time that another request was made for the aforementioned five consultants. The QIDP provided no additional information regarding the files before the surveyors exited the facility.</p>	1271	
1374	<p>3519.5 EMERGENCIES</p> <p>After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours</p>	1374	<p>The Director of Residential Services will meet with the IMC to reinforce the importance of insuring that proper notifications occur to DOH when an incident status changes from reportable to serious reportable. The QIDP and Facility Manager will also receive this feedback from the Director. The new Audit Consultant will monitor compliance on a routine basis...12-30-11</p>

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I 374 Continued From page 4
after the incident. ID PREFIX TAG: 1374

This Statute is not met as evidenced by:
Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for one of the two residents included in the sample. (Resident #2)

The finding includes:

(Cross Reference W153) On November 30, 2011, at 3:20 p.m., review of a radiology report dated November 19, 2010, revealed Resident #2 received an x-ray to the right foot. The result of the x-ray determined that the resident had a fractured fifth metatarsal.

Review of the facility's incident report and corresponding investigation on December 1, 2011, beginning at 10:00 a.m., revealed the facility failed to provide evidence that Resident #2's legal guardian and/or family members were made aware of the aforementioned incident. Interview with the QIDP on December 1, 2011, at approximately 2:00 p.m., revealed she did not know if the residents' guardian was made aware of the injury to Client #2's right foot.

At the time of the survey, the facility failed to provide evidence that Client #2's legal guardian was made aware of his injury.

I 401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS ID PREFIX TAG: 1401

Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent

MTS does have a protocol addressing obtaining medical appointment results in a timely manner and insuring they are reviewed by the required clinical professionals in a timely manner (See: the attached protocol). The protocol was developed in 2008 and nurses and staff that assist individuals supported during medical consultations were trained on its strategies. The protocol will be revised to clearly instruct nurses on how to follow up if they have difficulty obtaining a report...12-30-11
The DON will insure that nurses are retrained on the protocol and that DSPs are retrained on the protocol...1-15-12

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1401	<p>Continued From page 5</p> <p>deterioration or further loss of function by the resident.</p> <p>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 professional services that included treatment services, and services designed to prevent deterioration or further loss of functioning by the resident for two of four residents in the facility. (Resident #2)</p> <p>The finding includes:</p> <p>The facility's nursing services failed to obtain Resident #2's x-ray results timely.</p> <p>On November 30, 2011, at 3:20 p.m., review of the medical records revealed that Resident #2 received an x-ray of the right foot on November 19, 2010. The x-ray was a follow up from a previous injury that was discovered on October 16, 2010 through an emergency room visit. The results of the x-ray revealed that the resident had a fractured fifth metatarsal. Continued medical record review revealed the Registered Nurse (RN) did not obtain the x-ray results until January 19, 2011. The primary care physician (PCP) received the results on January 20, 2011, a day later.</p> <p>In a telephone interview with the licensed practical nurse (LPN) coordinator and a face to face interview with the RN on December 1, 2011, at 2:15 p.m., the LPN and the RN confirmed that they received the results of the x-ray on January 19, 2011, (2 months after the x-ray was taken). When asked, the LPN stated that she had made several phone calls to retrieve the results, but</p>	1401	<p>2011 VED</p> <p>2011 VED</p> <p>2011 VED</p>

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1401	Continued From page 6 was not able to produce any evidence of her efforts. She further revealed that through her continued efforts, she discovered that the hospital had Client #2's name in reverse and was subsequently able to obtain the needed x-ray.	1401	
1405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. 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 professional services had been provided in accordance with each resident's needs, for one of the two residents included in the sample. (Resident #2) The finding includes: Observation at the facility on November 29, 2011, at approximately 5:05 p.m., revealed the direct support staff (DSS) prepared Resident #2's water with thickener. Further observation revealed the water was prepared to a honey consistency. The DSS then spoon fed the resident his water. Interview with the DSS on the same day at approximately 5:15 p.m., confirmed that the water was prepared to a honey consistency. Observations at the day program on November 30, 2011, at 10:16 a.m., revealed the day program staff prepared Resident #2's water with	1405	The QIDP has shared this deficiency with the management staff of the day program who reassured the QIDP that this would be monitored routinely, effective immediately. The QIDP has scheduled a training session for the day program staff on thickening liquids to honey level for Client #2. This training will be implemented...1-17-12.

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1405	<p>Continued From page 7</p> <p>thickener. Further observation revealed the water was prepared to a pudding consistency. The day program staff then spoon fed the resident his water. Interview with the day program staff on the same day at approximately 10:20 a.m., confirmed the water was prepared to a pudding consistency.</p> <p>Review of Resident #2's physician orders on November 30, 2011, at 1:15 p.m., revealed the resident was prescribed a "honey thickened liquids diet".</p> <p>At the time of the survey the day program staff failed to serve Resident #2's water at the prescribed consistency.</p>	1405	

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R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on the interview and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for two of twelve staff employed. (Staffs #1 and #9)</p> <p>The finding includes:</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and review of the personnel files on December 1, 2011, beginning at 1:01 p.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a seven year listing of all jurisdictions where two staff worked and/or resided at the time of the survey. For example:</p> <ul style="list-style-type: none"> - There was no background conducted for Staff #1 who worked in the District of Columbia. - There was no background conducted for Staff #9 who worked in the District of Columbia. <p>At approximately 3:00 p.m., on December 1, 2011, the surveyor reviewed the aforementioned finding listed above with the QIDP. The QIDP acknowledged that criminal background checks were not conducted in all jurisdictions where staff</p>	R 125	<p>The two individuals cited will be rerun to insure that a District check is done...12-30-11 The District will be made an automatic part of the review process in the future...12-23-11</p>

Health Regulation & Licensing Administration

Debbie G. Moore, Director of Residential Services 12/23/11

(X5) DATE

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

