

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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>On March 27, 2012, at approximately 4:00 p.m., the State Agency was informed that Client #1 had been relocated to this facility from another ICF/IID operated by the same residential provider. The provider indicated the client was moved in order to remove an existing immediate jeopardy at the client's former residence.</p> <p>Due to the nature of the situation, surveyors from the Intermediate Care Facilities Division (ICFD) conducted a monitoring visit on March 28, 2012 to ensure the safety and well being of the clients and staff. The findings of the monitoring visit determined that conditions existed that posed an immediate risk to the health and safety of the clients and staff. At 4:00 p.m. the director of residential services (DRS) was notified that an immediate jeopardy existed. At 5:49 p.m., the DRS informed the State Agency that Client #1, who already received one-to-one staffing support, would begin receiving two-to-one staffing and was being transferred to a hotel. The immediate jeopardy, therefore, was lifted; however additional deficiencies that were identified during the monitoring visit remained.</p> <p>The findings of the monitoring visit were based on observations, interviews and record review. The results of the monitoring visit determined that the facility failed to maintain compliance with the Conditions of Participation of Governing Body and Client Protections.</p> <p>[Note: On March 29, 2012, a monitoring visit was conducted at the hotel where lodging was secured for Client #1. At 5:50 p.m., the hotel management staff indicated that on March 28,</p>	W 000	<p>A team meeting was conducted on March 19, 2012, to discuss alternative placement plans for Client #2. No decision on an alternative placement was made in that meeting but several alternatives were discussed. It was also decided in that team meeting to set up a second meeting after the March 27<sup>th</sup> psychotropic medication review so as to have the feedback and findings of that team to take into consideration. The incident involving Client #2 occurred on March 25<sup>th</sup>, two days before the planned psychotropic medication review.</p> <p>The incident elevated the situation to emergency status and team meetings to decide upon an appropriate alternative placement have occurred with the involvement of the DDS Service Coordinator, Client #2 mother, his attorney, the Quality Trust and MTS staff. A new placement has been chosen, external to MTS. It is an apartment setting with Client #2 getting his own room, a major consideration for him, and only one other housemate. MTS will coordinate with the new provider to ensure they have all of the information and records they need to effectively support Client #2...4-17-12.</p> <p>The new client on client abuse protocol outlines the steps to be taken if one individual presents a clear and present danger to another supported...4-16-12</p>		

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

TITLE

(X6) DATE

*Charles Chiagano For EVERTI MOORE DRS 5/8/12*

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.

*RECEIVED 5/8/12*

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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	Continued From page 1 2012, the client was registered for two nights of lodging, and was scheduled to check out on March 30, 2012. The hotel management staff also stated that on March 29, 2012, at approximately 5:00 p.m., the client left his room with two adult males, and had not yet returned. Discussion with the provider agency revealed that Client #1 was hospitalized due to aggressive behaviors.]	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT  The facility must ensure that specific governing body and management requirements are met.	W 102	The issues outlines in w102, 104 have been addressed ( see the response for each of the aforementioned tags in 104). 5 -7 -12	
W 104	This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104]  The effects of these systemic practices revealed that the facility's governing body failed to adequately govern the facility in a manner that would ensure the health and safety of all clients and staff. [See also W122] 483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observation, interview, and record	W 104	Protocol was written for Client #1 to have access to common areas of the home on March 28 <sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1 ,#2, #3 , #4 , #5 , and #6 safe at all times.	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 104	<p>Continued From page 2</p> <p>review, the governing body failed to exercise general operating direction over the facility to ensure the clients' health and safety, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>On the evening of March 27, 2012, the Director of Residential Services for the provider agency (Multi-Therapeutic Services, MTS) informed the State agency that Client #1 had been transferred to this facility from another facility operated by the same agency. The reason the client was relocated was to address the concerns that posed an immediate risk to clients' health and safety at his previous home. On March 28, 2012, a monitoring visit was initiated by the State Agency to ensure the health and safety of clients residing in the facility.</p> <p>1. The governing body failed to ensure that systems were developed and implemented to effectively address a client's aggressive and threatening behavior, thereby failing to protect the health and safety of clients and staff, as follows:</p> <p>On March 28, 2012, interviews with direct support as well as management staff in the new facility, at 7:00 a.m. and 10:35 a.m. respectively, revealed that the previous facility's protocol to secure knives (and sharp objects) and to provide one-to-one staffing (remain in direct line of vision) supports at all times was to be enacted at the new facility. However, observations on March 28, 2012, at 7:37 a.m. revealed that the one-to-one staff person (Staff #4) did not maintain the client in visual line of sight at all times. The staff left</p>	W 104	<p>Specific protocols have been developed to address client on client abuse ...4-16-12</p> <p>Staff were trained on the protocols on...4-20-12 Additionally, the individual BSP for Client #1 was modified to reflect proactive interventions for each of the target behaviors...4-20-12</p> <p>A revised BSP for client #1 reflecting proactive strategies to safeguard client #1 and other individuals as well as staff was implemented 3 - 28 -12</p> <p>Staff providing 1:1 services and staff at the temporary location received training on the new BSP to insure the health and safety of all individuals when involved in social interactions. 3 -28-12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 104	<p>Continued From page 3</p> <p>Client #1 alone in his bedroom while he (staff) went to the bathroom in the hallway to retrieve paper towels. Although all of the facility's knives were secured, at 8:04 a.m., the surveyors observed a pair of scissors on a desk in the office located adjacent to Client #1's bedroom. The client had to walk through the office in order to access other areas of the facility, including the bathroom. It should be noted that Staff #4 documented an incident of explosive behavior at 6:40 a.m. (i.e., hitting walls, cursing at the staff and screaming that he wanted to return to his previous home "to get" his former roommate) in that office and the adjoining hallway outside of the bathroom.</p> <p>Review of Client #1's behavior support plan (BSP), dated January 21, 2012, on March 28, 2012, at 7:25 a.m., revealed that it failed to identify clear instructions to staff on strategies to be implemented during incidents incidents of exhibited explosive behaviors. The BSP identified behavioral "explosive episodes" including physical aggression, property destruction, threats to hit, verbal or non-verbal posturing, and using furniture to harm.</p> <p>2. The governing body failed to ensure that staff on all shifts received training to ensure the safety of all clients and staff, as follows:</p> <p>a. There was no evidence that male staff working downstairs during the overnight shift had received training regarding Client #1's behavioral needs, as follows:</p> <p>1) On March 28, 2012, at 7:00 a.m., interview with a male direct support staff person (Staff #2)</p>	W 104	<p>A sweep of the residence was conducted on 3-28-12 to insure all sharp objects were properly secured. 3 -28 -12</p> <p>Staff training for 1:1 and staff of the Jay street residence was conducted on 3 -28 -12 to address insuring all sharp objects are properly secured.3 -28 -12</p> <p>BSP for client #1 was renewed/ trained for level of support required at all times and how to handle when 1:1 staff needs to be relieves for a brief period. 3 -28 -12</p> <p>The Behavior support plan was updated on 3 -28 -12 with staff training to provide clear instructions and strategies to implement to manage explosive episodes. 3 -28 -12</p> <p>1. Staff that manage individuals with aggressive behaviors receive CPI training aimed at preventing them from hurting themselves or anyone else and aimed at ensuring staff employ the safest methods possible, including early intervention at the prerequisite sign stage (i.e. before the behavior begins and when the person is showing know indicators that the behavior is about to occur)...4-16-12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019	
(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 104	<p>Continued From page 4</p> <p>who was assisting Client #3 at that time revealed that he had not been given information regarding Client #1's behavior support needs.</p> <p>When interviewed on March 28, 2012, beginning at 10:34 a.m., the Jay St. qualified intellectual disabilities professional (QIDP/Staff #7) stated that she and the evening male staff had been informed that Client #1 had "explosive behaviors" and was known to make "inappropriate sexual comments to females, and touch them." They further indicated that the client's behaviors had not been fully explained to them.</p> <p>2) When interviewed on March 28, 2012, beginning at 10:34 a.m., the QIDP/Staff #7 stated the house manager (HM/Staff #9) provided training for the male staff that were on duty during the evening shift on March 27, 2012. The HM had informed them that male staff from Jay St. would be allowed to "fill in" if/when Client #1's one-to-one needed a bathroom break. Interview with Staff #2, however, revealed no evidence that he was aware of those instructions.</p> <p>On March 28, 2012, at 11:40 a.m., review of a staff in-service training signature revealed no evidence that Staff #2 had received training.</p> <p>b. There was no evidence that Client #1's one-to-one staff (Staff #4) assigned to work the overnight shift had received training regarding the client's behavior intervention needs, as follows:</p> <p>Beginning at 7:16 a.m. Staff #4 was interviewed in Client #1's upstairs bedroom and the adjacent office area. He stated that he had received training on behavior management principles in</p>	W 104	<p>Clients #1 BSP includes management of explosive episodes. Staff documented the behavioral outburst on the ABC data sheet as per procedures. 3 -28 -12</p> <p>Revised BSP and client profile were reviewed with QDDP for temporary location and staff and clients #1 1:1 staff. 3 -28 -12</p> <p>Training for all staff was conducted on 3 -28 -12 following preliminary findings of the survey.</p> <p>Client #1 staff for overnight and all other 1:1 received training in the implication of BSP ( see attached signatures.</p> <p>Training on BSP was conducted for 1:1 staff and staff for the temporary location on 3 -28-12</p>

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
---	---

(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 104

Continued From page 5

general during new staff orientation but had not received training on Client #1's specific BSP.

At approximately 11:06 a.m., interview with the Lee St. QIDP (Staff #8) revealed that he had trained the one-to-one on the evening shift (Staff #10) but the other staff "will be trained" later that day.

On March 28, 2012, at 11:40 a.m., review of a staff in-service training signature sheet revealed no evidence that Staff #4 had received training since Client #1 transferred to the Jay St. facility.

c. There was no evidence that Staff #4 had received training regarding staffing needs, as follows:

On March 28, 29012, at approximately 8:25 a.m., Staff #4 indicated that he had been informed that he must keep the client within sight at all times. When asked about taking breaks, he replied he was unable to do so throughout his 8-hour shift.

At approximately 10:45 a.m., interview with the Jay St. QIDP (Staff #7) revealed that the HM had instructed Client #1's evening one-to-one (Staff #10) as well as the evening male staff working downstairs at Jay St. could "fill in" if/when the one-to-one needed a bathroom break. There was no evidence, however, that these instructions had been conveyed to Staff #4 prior to his 12:00 a.m. - 8:00 a.m. shift.

3. The governing body failed to ensure that less restrictive behavior intervention techniques were developed and implemented in the new facility, prior to implementing more restrictive techniques

W 104

Staff training as per indicated was conducted for all staff related to BSP and Client profile for Client #1 ( see in service sheet) 3 -28-12

BSP for client #1 was renewed/ trained for level of support required at all times and how to handle when 1:1 staff needs to be relieved for a brief period. 3 -28 -12

Protocol was written for Client #1 to have access to common areas of the home on March 28<sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1 ,#2, #3 , #4 , #5 , and #6 safe at all times.

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 104	<p>Continued From page 6</p> <p>with Client #1, such as medication increases and restrictions on his movement within the facility, as follows:</p> <p>[Cross-refer to W278]</p> <p>a. The facility failed to review and/or update Client #1's BSP prior to isolating him from other clients, as follows:</p> <p>On March 28, 2012, interviews with direct support staff (Staff #1, #2 and #3) in the new facility, beginning at 7:00 a.m., revealed that the client was living in a separate area of the house and was not permitted to intermingle with the other clients. At 7:16 a.m., the client's overnight one-to-one staff (Staff #4) stated the same. Between 7:16 a.m. and 9:16 a.m., Client #1 was observed upstairs in his separate living area. He came downstairs at 9:16 a.m., only after the other clients had left the facility.</p> <p>On March 28, 2012, at approximately 10:57 a.m., interview with the two QIDPs (Staff #7 and #8) confirmed that Client #1 was not permitted to intermingle with the other clients. This was in accordance with instructions received from management prior to the client's transfer from the other facility, and was to address the safety needs of the current residents.</p> <p>Continued interview with the QIDPs indicated that the human rights committee (HRC) had met on March 27, 2012 and reviewed Client #1's needs. There were no minutes available for review, however, to verify the extent of the discussion and/or decisions. There was no documented evidence that less-restrictive strategies were</p>	W 104	<p>Accommodations were made to give Clients #1 sense of having his own room and having activities area with using his own side entrance into his apartment as per his request. 4 -20- 12</p> <p>Protocol was written for Client #1 to have access to common areas of the home on March 28<sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1 ,#2, #3 , #4 , #5 , and #6 safe at all times.</p> <p>HRC meeting of March 29<sup>th</sup>, 2012, review the new BSP plan of March 28<sup>th</sup>, 2012. This plan addressed all Client #1 Target Behaviors, One on One staffing and also included Body Search protocol for objects that can be used as Weapons. The plan and the team also recommended that Client #1 should also use disposable plastic utensils as additional precautions. 4 - 20 - 12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019	
(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 104	<p>Continued From page 7</p> <p>proposed or implemented for the new facility, prior to the restriction of his movement within the facility.</p> <p>b. The facility failed to review and/or update Client #1's BSP prior to increasing his medications, as follows:</p> <p>At 10:45 a.m., interview with the QIDP/Staff #8 revealed that on March 27, 2012, the psychotropic medication team reviewed Client #1's medication regimen and recommended a doubling of his daily dosage of Thorazine (from 50 mg twice a day, to 50 mg in the morning and 150 mg in the evening). He indicated that the medication increase had been reviewed and approved by the HRC on the same day (March 27, 2012). The QIDP stated that the client was administered Thorazine 150 mg in the new facility on the evening of March 27, 2012.</p> <p>Earlier review of the BSP, at 7:25 a.m., and further interview with the QIDPs confirmed that the BSP, dated January 21, 2012, had not been revised since the immediate jeopardy was identified at his former residence. The QIDP/Staff #8 reported having spoken with the psychologist that morning (March 28, 2012). The psychologist reportedly planned to update the client's BSP later that day.</p> <p>On March 28, 2012, at 11:12 a.m., review of Client #1's physician's order sheets confirmed that the order for Thorazine had been increased to 50 mg in the morning and 150 mg in the evening, effective March 27, 2012.</p>	W 104	<p>Psychotropic med review meeting was scheduled for 3 -27 -12 to discuss alternative placement, alternative to management of concerns related to client #1. The incident involving client #1 occurred on March 25<sup>th</sup>, 2012, 2 days before the planned Psychotropic med review.</p> <p>The incident elevated to a situation requiring alternative medical strategies to manage client #1 that were received and approved by HRC for implementation 3 -27 -12. ( See attached HRC and consent from family)</p> <p>BSP for client #1 was revised on 3 -28 -12 with approval from HRC. Psychologist had completed two prior revisions that were not accepted by HRC. The final revision on 3 -28 -12 was approved for implementation on 3 -28 -12. HRC approval was completed 3 -28 -12 with staff training conducted on BSP following HRC approval.</p>
W 122	483.420 CLIENT PROTECTIONS	W 122	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/28/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4414-16 JAY STREET, NE</b> <b>WASHINGTON, DC 20019</b>		
(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 122	Continued From page 8 The facility must ensure that specific client protections requirements are met.  This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that systems were developed and implemented to effectively address a client's aggressive and threatening behavior, thereby failing to protect the health and safety of clients and staff [See W127].  The effects of these systemic practices resulted in the failure of the facility to protect its clients and staff from potential harm and to ensure their general safety and well being.	W 122	Accommodations were made to give Clients #1 sense of having his own room and having activities area with using his own side entrance into his apartment as per his request. 4 -20- 12	
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that systems were developed and implemented to effectively address a client's aggressive and threatening behavior, thereby failing to protect the health and safety of clients and staff, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)  The findings include:	W 127	Protocol was written for Client #1 to have access to common areas of the home on March 28 <sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1 ,#2, #3 , #4 , #5 , and #6 safe at all times.	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 127	<p>Continued From page 9</p> <p>On the evening of March 27, 2012, the Director of Residential Services for the provider agency (Multi-Therapeutic Services, MTS) informed the State agency that Client #1 had been transferred to this facility from another facility operated by the same agency. The reason the client was relocated was to address the concerns that posed an immediate risk to clients' health and safety at his previous home. On March 28, 2012, a monitoring visit was initiated by the State Agency to ensure the health and safety of clients residing in the facility.</p> <p>On March 28, 2012, interviews with direct support as well as management staff in the new facility, at 7:00 a.m. and 10:35 a.m. respectively, revealed that the previous facility's protocol to secure knives (and sharp objects) and to provide one-to-one staffing (remain in direct line of vision) supports at all times was to be enacted at the new facility. However, observations on March 28, 2012, at 7:37 a.m. revealed that the one-to-one staff person (Staff #4) did not maintain the client in visual line of sight at all times. The staff left Client #1 alone in his bedroom while he (staff) went to the bathroom in the hallway to retrieve paper towels. Although all of the facility's knives were secured, at 8:04 a.m., the surveyors observed a pair of scissors on a desk in the office located adjacent to Client #1's bedroom. The client had to walk through the office in order to access other areas of the facility, including the bathroom. It should be noted that Staff #4 documented an incident of explosive behavior at 6:40 a.m. (i.e., hitting walls, cursing at the staff and screaming that he wanted to return to his previous home "to get" his former roommate) in that office and the adjoining hallway outside of the</p>	W 127	<p>Staff #4 was re-train on the new BSP plan of March 28<sup>th</sup>, 2012. This plan addressed all Client #1 Target Behaviors, One on One staffing and also included Body Search protocol for objects that can be used as Weapons. 3 -28 -12</p> <p>BSP for client #1 was renewed/ trained for level of support required at all times and how to handle when 1:1 staff needs to be relieves for a brief period. 3 -28 -12</p> <p>Staff received training on implementation BSP and documentation on ABC if a targeted behavior occurs. 3 -28 -12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/28/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4414-16 JAY STREET, NE</b> <b>WASHINGTON, DC 20019</b>		
(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 127	<p>Continued From page 10 bathroom.</p> <p>Review of Client #1's behavior support plan (BSP), dated January 21, 2012, on March 28, 2012, at 7:25 a.m., revealed that it failed to identify clear instructions to staff on strategies to be implemented during incidents incidents of exhibited explosive behaviors. The BSP identified behavioral "explosive episodes" including physical aggression, property destruction, threats to hit, verbal or non-verbal posturing, and using furniture to harm.</p> <p>On March 28, 2012, surveyors were informed that the Human Rights Committee (HRC had met on March 27, 2012 and reviewed Client #1's needs. The qualified intellectual disabilities professional (QIDP/Staff #8) from Jay St. presented evidence that the HRC had reviewed the client's medications (specifically, the psychiatrist's recommendation to increase his Thorazine from 50 mg twice a day, to 50 mg in the morning and 150 mg in the evening). as well as one recent (March 25, 2012) incident involving explosive behaviors, including threats to do bodily harm with a knife. There were no minutes available for review, however, to verify the extent of the discussion and/or decisions. There was no documented evidence that less-restrictive strategies were proposed or implemented for the new facility, prior to the doubling of Client #1's Thorazine and the restriction of his movement within the facility.</p> <p>On March 28, 2012, at 12:35 p.m., surveyors interviewed Client #1's psychiatrist regarding a statement in the HRC minutes dated January 24, 2012. On that date, the minutes revealed the</p>	W 127	<p>The increase in medication preceded more to new facility. Increase in medication was related to the incident on 3 -25 -12. Increase in medication was addressed at Psychotropic med review meeting with approval from the HRC. Staff training related to increase and the side effects was reviewed with 1:1 to insure</p> <p>Clients #1 safety during temporary accommodation.</p> <p>HRC meeting of March 29<sup>th</sup>, 2012, review the new BSP plan of March 28<sup>th</sup>, 2012. This plan addressed all Client #1 Target Behaviors, One on One staffing and also included Body Search protocol for objects that can be used as Weapons. The plan and the team also recommended that Client #1 should also use disposable plastic utensils as additional precautions. 4 - 20 - 12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019	
(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 127	Continued From page 11 client was in a homicidal state, and the committee expressed concern for the other individuals' safety. During the interview on March 28, 2012, the psychiatrist indicated that the client would not kill anyone, but could accidentally injure someone.  Based on the above findings, HRLA identified an immediate jeopardy at the Jay St. facility. The director of residential services (DRS) for MTS was notified at 4:00 p.m. At 5:49 p.m., the DRS submitted a credible allegation of compliance to remove the immediate risk to clients' health and safety.	W 127	
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's qualified intellectual disabilities professional (QIDP) failed to coordinate necessary services and interventions to ensure clients' safety, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)  The findings include:  1. The QIDP failed to ensure that Client #1's behavior support plan (BSP) documented strategies and interventions to address his explosive behaviors, as follows:  On the evening of March 27, 2012, the Director of	W 159	The QDDP will insure that all active treatment programs are integrated coordinated and monitored. 3 -28 -12  Protocol was written for Client #1 to have access to common areas of the home on March 28 <sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1, #2, #3, #4, #5, and #6 safe at all times.  A specific protocol has been developed addressing Client on Client abuse...4-16-12  Staff were be trained on the protocol on 4-20-12 All new staff will be trained on both of the aforementioned protocols during their initial orientation and long term staff will receive refresher training at minimum annually...4-20-12

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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	<p>Continued From page 12</p> <p>Residential Services for the provider agency (Multi-Therapeutic Services, MTS) informed the State agency that Client #1 had been transferred to this facility from another facility operated by the same agency. The reason the client was relocated was to address the concerns that posed an immediate risk to clients' health and safety at his previous home. On March 28, 2012, a monitoring visit was initiated by the State Agency to ensure the health and safety of clients residing in the facility.</p> <p>Client #1's one-to-one staff (Staff #4), was interviewed on March 28, 2012, beginning at 7:16 a.m., regarding Client #1's adjustment to his new home. Staff #4 indicated that the client had slept through the night. Further interview revealed that beginning at 6:40 a.m., the client had an incident of explosive behavior (i.e., hitting walls, cursing at the staff and screaming that he wanted to return to his previous home "to get" his former roommate).</p> <p>At 7:25 a.m., Staff #4 presented a behavior support plan (BSP), dated January 21, 2012, which was available for guidance. The BSP addressed explosive behaviors, including physical aggression and threats to do bodily harm. When asked how he would address situations where the client's behavior became explosive, Staff #4 replied he would tell him "I'm here for you, stop," and the client would comply. When asked what he would do if his verbal directives were ignored, Staff #4 replied he would call 911 if the client became physically assaultive.</p> <p>Review of Client #1's behavior support plan (BSP), dated January 21, 2012, on March 28,</p>	W 159	<p>Staff training on BSP and documentation of target behaviors on ABC was completed. Staff retraining on BSP proactive strategies , documentation on ABC and incidents will be addressed. 4 -20 -12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/28/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4414-16 JAY STREET, NE</b> <b>WASHINGTON, DC 20019</b>		
(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	<p>Continued From page 13</p> <p>2012, at 7:25 a.m., revealed that it failed to identify clear instructions to staff on strategies to be implemented during incidents of exhibited explosive behaviors. The BSP identified behavioral "explosive episodes" including physical aggression, property destruction, threats to hit, verbal or non-verbal posturing, and using furniture to harm.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP/Staff #8) on March 28, 2012, at 10:52 a.m., confirmed that Client #1 had a BSP, dated January 21, 2012. The QIDP/Staff #8 essentially repeated what Staff #4 had stated regarding explosive behavioral incidents, giving verbal redirection and calling 911 if Client #1 attempted to hit anyone. He then acknowledged that the BSP failed to identify clear instructions to staff on strategies to be implemented during incidents of exhibited explosive behaviors.</p> <p>2. The QIDP failed to ensure that staff on all shifts received training regarding Client #1's need for visual supervision at all times, as required by his BSP, as follows:</p> <p>[Cross-refer to W189 and W249] On March 28, 2012, at 7:37 a.m., Client #1 informed his one-to-one staff (Staff #4) that his nose was running. A thin strand of mucous was observed dangling from the client's nose. At 7:38 a.m., Staff #4 left the bedroom, walked quickly through the office and into an adjacent bathroom, briefly leaving the client out of view. The staff returned with several paper towels in his hand, folding them as he walked. The staff assisted him with taking a seat and the client wiped his nose.</p>	W 159	<p>BSP was revised on 3 -28 -12 to address clear instructions procedures and strategies during explosive episodes, staff training was conducted an updated. 3 -28-12</p> <p>BSP for client #1 was renewed/ trained for level of support required at all times and how to handle when 1:1 staff needs to be relieves for a brief period. 3 -28 -12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 14 At 7:25 a.m., review of Client #1's BSP, dated January 21, 2012, revealed that the one-to-one staff was assigned "due to his medical concerns." Continued review of the BSP revealed the following: "Counselor supervision is maintained at all times... supervise him at all times for safety and signs of Stage 1 behaviors. Be visually aware of him at all times."  Beginning at approximately 8:15 a.m., Staff #4 was interviewed in the facility driveway. He acknowledged that he had left the client alone when he went to get paper towels from the bathroom.  Beginning at 10:34 a.m., interview with the Jay St. QIDP/Staff #7 revealed that the house manager (HM/Staff #9) provided training for male staff working the evening shift (4:00 p.m. - 12:00 a.m.) on the day before. The HM had informed them that the one-to-one staff should remain with Client #1 at all times. Male staff from Jay St. (working downstairs) would be allowed to "fill-in" if/when the one-to-one needed to take a break. However, interview with the (male) Staff #2 working downstairs on the 12:00 a.m. - 8:00 a.m. shift, at 6:59 a.m., revealed no evidence that he was aware of that arrangement (i.e., that he should be available to fill-in briefly for Client #1's one-to-one staff if needed). And as noted above, interview with the overnight one-to-one (Staff #4) at approximately 8:20 a.m., revealed no evidence that he had been made aware of that provision for staff coverage.	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the	W 189			

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/28/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4414-16 JAY STREET, NE</b> <b>WASHINGTON, DC 20019</b>		
(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 189	<p>Continued From page 15</p> <p>employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each staff, including the overnight shift, was effectively trained to meet the behavior management and safety needs of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>1. There was no evidence that male staff working downstairs during the overnight shift had received training regarding Client #1's needs, as follows:</p> <p>a. On March 28, 2012, at 7:00 a.m., interview with a male direct support staff person (Staff #2) who was assisting Client #3 at that time revealed that he worked the 12:00 a.m. - 8:00 a.m. shift. He indicated that the staff who had been assisting Client #3 at the time that he (Staff #2) came on duty had informed him that a new client was in an upstairs bedroom with a one-to-one staff. When asked if he had been given information regarding Client #1's behavior support needs, Staff #2 replied "not really." [Note: Client #1 was transferred to this facility on the previous day (March 27, 2012) following an immediate jeopardy that was based largely on his targeted maladaptive behaviors. For example, he had demonstrated 95 incidents of explosive behaviors during the period January 1, 2012 through March 26, 2012. These incidents included 22 documented episodes of hitting other clients, 14 incidents of hitting staff and 42 incidents of verbal</p>	W 189	<p>Protocol was written for Client #1 to have access to common areas of the home on March 28<sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1, #2, #3, #4, #5, and #6 safe at all times.</p> <p>All staff were trained on revised BSP protocol for safety and client profile</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 189	<p>Continued From page 16</p> <p>aggression, including 23 threats to kill others. There had been two recent incidents in which the client held a knife and threatened to do bodily harm.]</p> <p>When interviewed on March 28, 2012, beginning at 10:34 a.m., the Jay St. qualified intellectual disabilities professional (QIDP/Staff #7) stated that she and the evening male staff had been informed that the client had "explosive behaviors" and was known to make "inappropriate sexual comments to females, and touch them." They further indicated that the client's behaviors had not been fully explained to them. At 11:05 a.m., interview with the QIDP from his former home (Staff #8) revealed that it was his understanding that the male staff working with the other clients downstairs were to be trained later that day. When the HM was interviewed, beginning at 11:37 a.m., she conveyed information consistent with what Staff # 7 and #8 had reported.</p> <p>b. When interviewed on March 28, 2012, beginning at 10:34 a.m., the QIDP/Staff #7 stated she was present when the house manager (HM/Staff #9) provided training for the male staff that were on duty during the evening shift on March 27, 2012. The HM had informed them that Client #1's one-to-one staff would remain with him at all times. However, male staff from Jay St. would be allowed to "fill in" if/when the one-to-one needed a bathroom break. Previously, interview with Staff #2 revealed no evidence that he was aware of that arrangement (i.e., that he should be available to fill-in briefly for Client #1's one-to-one staff if needed).</p> <p>On March 28, 2012, at 11:40 a.m., review of a</p>	W 189	<p>Staff training QDDP for Jay Street training</p> <p>Staff fill in when needing bathroom.</p>		

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 189	Continued From page 17 staff in-service training signature sheet presented by the HM revealed evidence that the evening one-to-one staff (Staff #10) for Client #1 had received training on March 27, 2012 regarding the client's temporary placement at Jay St., his BSP and the one-to-one protocol. There was no evidence, however, that Staff #2 had received similar training.  2. There was no evidence that Client #1's one-to-one staff (Staff #4) assigned to work the overnight shift had received training regarding the client's behavior intervention needs, as follows:  On March 28, 2012, at 7:37 a.m., Client #1 informed his one-to-one staff (Staff #4) that "my nose run." The client's head was facing downward and a thin strand of mucous was observed dangling from his nose. The staff offered to get him some tissue. At 7:38 a.m., Staff #4 left the bedroom, walked quickly through the office and into an adjacent bathroom, briefly leaving the client out of view. The staff returned with several paper towels in his hand, folding them as he walked. Once Client #1 had a paper towel in his left hand, he informed the staff "I'm going to fall." The client, who had been moving slowly and appeared lethargic for the past 20 minutes, was hunched over, holding the paper towel in his left hand and holding a cup of water in his right hand. The client repeated his statement that he was going to fall. Staff #4 replied "come and sit on this chair." The staff assisted him with taking his seat and the client wiped his nose.  At 7:25 a.m., review of Client #1's behavior support plan (BSP), dated January 21, 2012, revealed that the one-to-one staff was assigned	W 189			

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 189	<p>Continued From page 18</p> <p>"due to his medical concerns." Continued review of the BSP revealed the following: "Counselor supervision is maintained at all times...supervise him at all times for safety and signs of Stage 1 behaviors. Be visually aware of him at all times."</p> <p>Interview with Staff #4 on March 28, 2012, beginning at 7:16 a.m. revealed that he worked the 12:00 a.m. - 8:00 a.m. shift. He further indicated that he had started working with Client #1 approximately two months earlier. When asked whether he had received training on Client #1's behavior support plan (BSP), Staff #4 stated that he had received training on behavior management principles in general during new staff orientation but had not received training on Client #1's specific BSP. He further indicated that he had read through the BSP as well as some of the behavior-related documentation on his own.</p> <p>3. There was no evidence that Client #1's one-to-one staff (Staff #4) assigned to work the overnight shift had received training regarding staffing needs, as follows:</p> <p>At approximately 8:25, while Staff #4 was being interviewed in the facility's driveway, he stated that he had been informed that he must keep the client within sight at all times. When asked about taking breaks, he replied he was unable to do so. He further indicated that he had not taken any breaks the night before, including no bathroom break. [Note: When reminded about the client's runny nose and request for tissue, Staff #4 acknowledged that he had left the client alone when he went to get paper towels from the bathroom.]</p>	W 189			

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 189	Continued From page 19 At approximately 10:45 a.m., interview with the QIDP (Staff #7) revealed that the HM had instructed Client #1's evening shift one-to-one (Staff #10) and the evening male staff downstairs that the male staff working downstairs at Jay St. could "fill in" if/when the one-to-one needed a bathroom break. There was no evidence, however, that this information had not been conveyed to Staff #4 for his 12:00 a.m. - 8:00 a.m. shift.	W 189			
W 234	QIDP at Client #1's former residence (Staff #8) 483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure methods were included in each client's behavior support plan that provided clear direction to staff on strategies to address a client's explosive episodes, for one of one client in the sample. (Client #1)  The finding includes:  [Cross-refer to W127.] On the evening of March 27, 2012, the Director of Residential Services for the provider agency (Multi-Therapeutic Services, MTS) informed the State agency that Client #1 had been transferred to this facility from another facility operated by the same agency. The reason the client was relocated was to address the concerns that posed an immediate risk to clients' health and safety at his previous home. On March 28, 2012, a monitoring visit was initiated by the State Agency to ensure the health and safety	W 234	The IMC has been instructed by the Director of Residential Programs to make an immediate phone call to the designated line at HLRA to report situations that involve allegations of mistreatment or abuse and to follow up with an immediate email...4-16-12  Staff will be retrained to report immediately allegations of abuse/neglect situations...4-20-12		

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 234	<p>Continued From page 20 of clients residing in the facility.</p> <p>Client #1's one-to-one staff (Staff #4), was interviewed on March 28, 2012, beginning at 7:16 a.m., regarding Client #1's adjustment to his new home. Staff #4 indicated that the client had slept through the night. Further interview revealed that beginning at 6:40 a.m., the client had an incident of explosive behavior (i.e., hitting walls, cursing at the staff and screaming that he wanted to return to his previous home "to get" his former roommate).</p> <p>At 7:25 a.m., Staff #4 presented a behavior support plan (BSP), dated January 21, 2012, which was available for guidance. The BSP addressed explosive behaviors, including physical aggression and threats to do bodily harm. When asked how he would address situations where the client's behavior became explosive, Staff #4 replied he would tell him "I'm here for you, stop," and the client would comply. When asked what he would do if his verbal directives were ignored, Staff #4 replied he would call 911 if the client became physically assaultive.</p> <p>Review of Client #1's behavior support plan (BSP), dated January 21, 2012, on March 28, 2012, at 7:25 a.m., revealed that it failed to identify clear instructions to staff on strategies to be implemented during incidents of exhibited explosive behaviors. The BSP identified behavioral "explosive episodes" including physical aggression, property destruction, threats to hit, verbal or non-verbal posturing, and using furniture to harm.</p> <p>Interview with the qualified intellectual disabilities</p>	W 234			

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019
---	---

(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 234 Continued From page 21  
professional (QIDP/Staff #8) on March 28, 2012, at 10:52 a.m., confirmed that Client #1 had a BSP, dated January 21, 2012. The QIDP/Staff #8 essentially repeated what Staff #4 had stated regarding explosive behavioral incidents, giving verbal redirection and calling 911 if Client #1 attempted to hit anyone. He then acknowledged that the BSP failed to identify clear instructions to staff on strategies to be implemented during incidents of exhibited explosive behaviors.

W 234

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION  
  
As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

W 249

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, facility staff failed to implement all behavior support plans in accordance with clients' Individual Program Plans, for one of one client in the sample. (Client #1)

The finding includes:

[Cross-refer to W127] On March 28, 2012, at 7:37 a.m., Client #1 informed his one-to-one staff (Staff #4) that "my nose run." The client's head was facing downward and a thin strand of mucous was observed dangling from his nose. The staff offered to get him some tissue. At 7:38

Client #1 BSP was revised on 3 -28-12 with clear instructions for implementation if a targeted behavior should occurs. Proactive strategies have been identified in an effort to minimize episodes. Staff training was conducted on 3 -28 -12 following HRC approval

All BSP's for individuals at client #1 prior residence before temporary relocation will be completed by 4 -20 -12

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 249	<p>Continued From page 22</p> <p>a.m., Staff #4 left the bedroom, walked quickly through the office and into an adjacent bathroom, briefly leaving the client out of view. The staff returned with several paper towels in his hand, folding them as he walked. Once Client #1 had a paper towel in his left hand, he informed the staff "I'm going to fall." The client, who had been moving slowly and appeared lethargic for the past 20 minutes, was hunched over, holding the paper towel in his left hand and holding a cup of water in his right hand. The client repeated his statement that he was going to fall. Staff #4 replied "come and sit on this chair." The staff assisted him with taking his seat and the client wiped his nose.</p> <p>At 7:25 a.m., review of Client #1's behavior support plan (BSP), dated January 21, 2012, revealed that the one-to-one staff was assigned "due to his medical concerns." Continued review of the BSP revealed the following: "Counselor supervision is maintained at all times...supervise him at all times for safety and signs of Stage 1 behaviors. Be visually aware of him at all times."</p> <p>At approximately 8:15 a.m., Staff #4 was interviewed in the facility driveway. Initially, he stated that he had spent the entire 12:00 a.m. - 8:00 a.m. shift in Client #1's bedroom. He explained that as a one-on-one staff, he was responsible for keeping the client within sight at all times. When asked about taking breaks, Staff #4 replied he was unable to do so. He had not taken any breaks the night before, including no bathroom break. When reminded of the client's runny nose, Staff #4 acknowledged that he had left the client alone when he went to get paper towels from the bathroom.</p>	W 249	<p>BSP for client #1 was renewed/ trained for level of support required at all times and how to handle when 1:1 staff needs to be relieved for a brief period. 3 -28 -12</p>	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 249	Continued From page 23 There was no evidence that the facility ensured that Client #1 received visual supervision at all times, as required by his BSP.	W 249	Training on BSP and protocols for staff were conducted on all staff at client #1 residence prior to temporary relocation will be trained in procedure to use when requiring relief 3 – 28 - 12		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that programs incorporating the use of less intrusive or more positive techniques had been tried systematically, and were demonstrated to be ineffective, before using more restrictive techniques, for one of one client in the sample. (Client #1)  The findings include:  1. The facility failed to review and/or update Client #1's behavior support plan (BSP) prior to isolating the client from other clients, as follows:  On March 27, 2012, Multi Therapeutic Services (MTS) relocated Client #1 from another facility operated by the same agency to 4414-16 Jay Street, N.E. On March 28, 2012, interviews with direct support staff (Staff #1, #2 and #3) in the new facility, beginning at 7:00 a.m., revealed that the client was living in a separate area of the house and was not permitted to intermingle with	W 278		Protocol was written for Client #1 to have access to common areas of the Jay Street residence on March 27 <sup>th</sup> 2012. This protocol emphasis on how staff would manage Client #1 aggressive behavior and keep Clients #1, #2, #3, #4, #5, and #6 safe at all times.  Accommodations were made to give Clients #1 sense of having his own room and having activities area with using his own side entrance into his apartment as per his request. 4 -20- 12	

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 278	<p>Continued From page 24</p> <p>the other clients. At 7:16 a.m., the client's overnight one-to-one staff (Staff #4) stated the same. Between 7:16 a.m. and 9:16 a.m., Client #1 was observed upstairs in his separate living area. He came downstairs at 9:16 a.m., only after the other clients had left the facility for day program.</p> <p>On March 28, 2012, at approximately 10:57 a.m., interview with the two qualified intellectual disabilities professionals (Staffs #7 and #8) confirmed that Client #1 was not permitted to intermingle with the other clients. This was in accordance with instructions received from management prior to the client's transfer from the other facility, to address the safety needs of the current residents.</p> <p>Continued interview with the QIDPs indicated that the human rights committee (HRC) had met on March 27, 2012 and reviewed Client #1's needs. They presented evidence that the HRC had reviewed the client's medications as well as one recent (March 25, 2012) incident involving explosive behaviors, including threats to do bodily harm with a knife. There were no minutes available for review, however, to verify the extent of the discussion and/or decisions. There was no documented evidence that less-restrictive strategies were proposed or implemented for the new facility, prior to the restriction of his movement within the facility.</p> <p>2. The facility failed to review and/or update Client #1's BSP prior to the increasing the client's medications, as follows:</p> <p>At 10:45 a.m., interview with the QIDP (Staff #8)</p>	W 278		

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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 278	<p>Continued From page 25</p> <p>revealed that on March 27, 2012, the psychotropic medication team reviewed Client #1's medication regimen and recommended a doubling of his daily dosage of Thorazine (from 50 mg twice a day, to 50 mg in the morning and 150 mg in the evening). He indicated that the medication increase had been reviewed and approved by the HRC on the day before (March 27, 2012). Staff #8 stated that the client was administered Thorazine 150 mg on March 27, 2012. Further discussion with the QIDP revealed the client was also currently prescribed several other psychotropic medications to manage his behaviors, in conjunction with an approved BSP.</p> <p>However, previous review of the BSP, at 7:25 a.m., and further interview with the QIDPs confirmed that the BSP had not been revised since the immediate jeopardy was identified at Client #1's previous residence. The same BSP, dated January 21, 2012, was being used at the current residence. The QIDP/Staff #8 reported having spoken with the psychologist that morning (March 28, 2012). The psychologist reportedly planned to update the client's BSP later that day.</p> <p>On March 28, 2012, at 11:12 a.m., review of Client #1's physician's order sheets confirmed that the order for Thorazine had been increased to 50 mg in the morning and 150 mg in the evening, effective March 27, 2012.</p> <p>At the time of the survey, there was no evidence that the facility ensured that programs incorporating the use of less intrusive or more positive techniques had been tried systematically, and were ineffective in managing the Client #1's behavior after he transferred to the Jay St. facility.</p>	W 278			

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

PRINTED: 04/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/28/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(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	