

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

PRINTED: 07/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3818 ALBERMARLE STREET NW WASHINGTON, DC 20008
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W 000 INITIAL COMMENTS

A recertification survey was conducted from 6/16/2010 through 6/18/2010. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of six men with various degrees of intellectual and/or developmental disabilities.

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

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to investigate serious reportable incidents to ensure the health and safety of one of six clients. [Client #3]

The finding includes:

- Record review on 6/16/2010 at 11:45 a.m. revealed six (6) unusual incidents were on file at the time of survey in Client #3's records. Further review revealed there were no investigations on file for any of the six unusual incidents reviewed. A listing of the unusual incidences is as follows:
 - 2/24/2010 - Client #3 was taken to the emergency room (ER) for constipation/moderate fecal impaction.

W 000

Received 7/19/10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

W 154

In the future, all unusual incidents will be thoroughly investigated and all reports submitted within five days. QMRP/ Manager will review all incidents monthly to ensure completion of investigation reports.

7/29/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Constantine C. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>7/16/10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 154	<p>Continued From page 1</p> <p>b. 11/13/2009 - Client #3 was combative with staff and sustained a laceration on the upper right side of his back.</p> <p>c. 8/31/2009 - another resident bumped into Client #3 and caused him to fall. He sustained a laceration to the front left side of his head. Client #3 was transported to the emergency room (ER) at a local hospital and treated with "dermabond" for laceration and discharged.</p> <p>d. 6/22/2009 - Client #3's one-to-one staff observed him fall while trying to walk up the stairs. As a result, Client #3 sustained two bruises and an abrasion on his left forehead.</p> <p>e. 6/13/2010 - A nursing note entered on the 6/2010 medication administration record (MAR) indicated Client #3 was found with an injury of unknown origin. One of the facility's direct support staff informed the nurse that a bruise was found on Client #3's left arm.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 6/18/2010 at approximately 4:05 p.m. revealed she was not sure why there were no incident reports on file for the five incident reports. The QMRP further stated that she would look into it and see if she had copies of the investigations at the main office.</p> <p>There was no evidence presented or on file at the time of survey to substantiate that all incidents of either emergent care or of unknown origin were investigated to ensure the health and safety of the residents.</p>	W 154		
W 159	483.430(a) QUALIFIED MENTAL	W 159		

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W 159	<p>Continued From page 2 RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for two of three clients in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to coordinate services to ensure Client #2's behavior support plan (BSP) was consistently implemented, as evidenced below:</p> <p>On 6/16/10 at 12:15 p.m., Client #2 was observed seated at a table at his day program holding a plastic bag, which contained 2 Ho Ho chocolate cake rolls, a 6.75 ounce Hi C box drink, and a 16 ounce Regular Coke. The case manager indicated that the client brings these almost every day. At 12:20 p.m., the client received a ground meal (chicken nuggets, cauliflower medley, steak fries) and milk, which he consumed approximately 80%.</p> <p>Interview with the case manager on 6/16/10 at 12:25 p.m., revealed the client was prescribed a 1500 calorie, soft diet. The case manager revealed that although nutritious and low calories snacks were available at the day program, it had difficult had to get the client to select them.</p>	W 159	<p>1. QMRP will coordinate a meeting with Client #2's Interdisciplinary team to develop strategies to decrease consumption of high calorie snacks. Direct Care Staff will receive training on Client #2's Behavior Support Plan. The QMRP will ensure that Behavior support Plan is consistently implemented.</p>	8/3/10
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W 159	<p>Continued From page 3</p> <p>because he seemed to prefer concentrated sweets, such as cakes and regular sodas. The case manager stated that the client's selection of inappropriate snacks had been discussed at his quarterly meeting on 2/5/10, however, the meeting had not resulted in a sustained change in the nutritional quality of the client's snack selections.</p> <p>On 6/16/10, at 3:52 p.m., Client #2 was observed at the dining table of his group home eating a Ho Ho creme filled chocolate cake roll and drinking a 16 ounce Coke. Observation of the dinner meal at approximately 5:25 p.m. revealed the client drank another 16 ounce Coke, however only ate approximately 10% of his meal.</p> <p>On 6/17/10 at 6:45 a.m., Client #2 was observed in the kitchen of the group home with a plastic container in which there were 2 Ho Ho chocolate creme-filled cakes and a 6.75 ounce Hi C box drink. (A partial case of Hi C was observed in the basement storage room.) The client was then observed asking for a soda. When staff told him there was no soda, he began to persistently request quarters.</p> <p>Interview with the QMRP on 6/18/10 at 11:40 a.m. acknowledged that Client #2's selection of inappropriate, high calories snacks had been a problem in the past. The QMRP stated that the client buys the sodas when he goes out to the volunteer site from his day program. She referenced the interdisciplinary discussion concerning this issue at the client's 2/1/10 quarterly meeting. According to the QMRP, the client's behavior support plan (BSP) had been approved to allow him to purchase a healthy snack. The QMRP stated that the client only</p>	W 159		
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W 159	<p>Continued From page 4</p> <p>received snacks approved by the nutritionist from the group home. Additionally, she indicated that the direct support staff had been instructed to teach the client to purchase only nutritious snacks.</p> <p>On 6/18/10 at 12:17 p.m., review of Client #2 BSP (Cognitive plan) dated 10/24/09 revealed a section entitled, "Quarters." The background notes revealed the client had a preoccupation of "having quarters on his person." The BSP also revealed that "numerous plans and standard procedures had been ineffective, due partly to their complicated procedures, the need for absolute consistency of all involved, and the client's overwhelming compulsion with quarters, as manifested by intense, persistent, and unyielding begging, borrowing, refusing to cooperate, tantruming and pestering."</p> <p>Continued review of the BSP on 6/18/10 at 12:22 p.m., revealed that Client #2's BSP included an objective that he "will use the quarters appropriately 100% of the trials." The BSP further noted: " he has often manipulated new staff or any staff who have attempted to develop money or food related plans for him. [Client #2] should not be allowed to build up huge quantities of quarters, food or drinks at home or his day program. This plan is needed because in the past this has caused trouble. He should not be allowed to buy anything not on his diet. The client's BSP, however, failed to specify what staff should do when the client was observed to have already purchased foods not on his diet when he was picked up from his day program.</p> <p>At the time of the survey, there was no evidence the QMRP had coordinated with Client #2's the</p>	W 159		
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W 159	<p>Continued From page 5</p> <p>interdisciplinary team, including the day program to develop effective strategies to reduce his purchasing of empty calorie snack foods.</p> <p>2. The QMRP failed to ensure coordinate nutrition services for the development of a plan for snacks, within the framework of Client #2's prescribed therapeutic diet, as evidenced below:</p> <p>Interview with the QMRP on 6/18/10 at 11:40 a.m. revealed the nutritionist had provided an approved list of snacks to be used at the group home. The QMRP indicated that the nutritionist was aware that the client's purchasing snacks, such as the Ho Hos had been a problem, and that he tended to be non-compliant with his diet. Additionally, the QMRP indicated that the interdisciplinary team was aware of, and attempting to address the snacking issue, and the kicking and screaming behavior exhibited when he did not get his preferred snacks.</p> <p>The review of the annual nutritional assessment dated 8/7/09, on 6/18/10 at 11:12 a.m. had revealed "He likes juice and sodas." The assessment had also revealed "Provide low calorie snack list... Offer water with meals and snacks... Continue to review nutrition regime with day placement." The subsequent review of the provided list of snack foods, however, had revealed that most of the foods were inappropriate to the client's caloric, sodium, or soft texture dietary restrictions.</p> <p>At the time of the survey, there was no evidence, services had been coordinated to maximize Client #2's compliance with his therapeutic dietary regimen.</p>	W 159	<p>2. QMRP will coordinate a meeting with Client #2's nutritionist to discuss the development of a plan for snacks for Client #2. Direct Care Staff will be trained on the implementation of nutrition plan for Client #2. QMRP will ensure that nutrition regimen is followed.</p>	8/3/10

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W 159	Continued From page 6 3. The QMRP failed to investigate serious reportable incidents to ensure the health and safety of its clients. [See W154] 4. The QMRP failed to ensure staff was effectively trained to implement walking/ambulation protocols and mealtime feeding protocols for Client #3. [See W192] 5. The QMRP failed to secure consent prior to sedating a Client #3 for medical treatment. [See W263] 6. The QMRP failed to ensure the residential staff provided meals for Client #3 in the form and texture as prescribed. [See W474]	W 159	3. Cross reference W154 4. Cross reference W192 #2 5. Cross reference W263 6. Cross reference W192 #1	7/19/10 8/10/10 7/19/10 8/3/10
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff was competent in implementing the modified food texture and ambulation protocols for one of the three sampled clients. [Client #3] The findings include: 1. [Cross Reference W474] Client #3 was not provided a "chopped" textured meal on the evening of 8/17/2010. His two and a half (2 1/2) inch round potatoes were cut in half and served whole. The observation was later confirmed via interviews with the facility	W 192	1. Direct Care Staff will receive training by the nutritionist on the diet and textured meals of Client #3. QMRP will ensure that Client diet is followed.	8/3/10

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W 192	<p>Continued From page 7</p> <p>'s qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/18/2010. The QMRP indicated she would address the oversight immediately.</p> <p>2. Observation on 6/18/2010 at approximately 4:15 p.m., revealed Client #3 's one-to-one staff (evening shift) provided ambulation assistance by standing slightly behind him and supporting his waist and one arm as he walked. Observation on 6/17/2010 at approximately 11:40 a.m. revealed Client #3 's one-to-one staff (day shift) provided support by placing his left arm underneath Client #3 's right arm to provide lift and support as they walked to the bathroom. That same technique was again used by the staff when they returned from the bathroom and returned to his seat. On both occasions, Client #3 was observed trying to lean forward as he ambulated to his destination. Both staff provided direct physical assistance to straighten him out until he reached his destination.</p> <p>Record review on 6/17/2010 at 2:28 p.m. revealed part of Client #3's walking protocol dated 7/18/2008 provided the following interventions:</p> <p>a. Staff should provide [Client #3] with physical assistance by placing their arm under his waist by holding on to his gait belt.</p> <p>b. During ambulation, staff should stand to the side of [Client #3].</p> <p>c. Staff should provide verbal prompts to [Client #3] so he can walk upright as much as possible.</p> <p>d. When [Client #3] begins to lean forward or walk</p>	W 192	<p>2. Direct Care Staff will receive training on Client #3's ambulation protocol. QMRP will ensure that training of the walking protocol occurs on at least an annual basis and that interventions are being properly implemented.</p>	8/10/10
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W 192	Continued From page 8 too fast, staff should have him completely stop walking then start again. The walking protocol confirmed that staff failed to use the gait belt as prescribed; failed to consistently stand by the "side" of the client during ambulation; failed to provide verbal prompts to encourage him to walk upright as much as possible; and failed to ensure they stopped walking whenever Client #3 attempted to lean forward when ambulating. Interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/18/2010 at 3:58 p.m. confirmed there has been no staff training from the physical therapist to address the interventions outlined in the walking program over the past year. Both the QMRP and the RN indicated the lack of staff training and oversight by the PT is probably the cause for the staff not consistently implementing the walking protocol.	W 192			
W 193	483.430(a)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for one of three clients in the sample. (Clients #2) The findings include:	W 193			

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W 193	Continued From page 9 1. Cross-refer to W159.1. On 6/16/10 (12:15 p.m.) and 6/17/10 (8:32 a.m.), Client #2 was observed holding a bag snack with contained only high sugar foods. On 6/18/10 at 3:52 p.m., he was observed eating the aforementioned snack. Interview with the QMRP on 6/18/10 at 11:40 a.m. acknowledged that Client #2 selecting inappropriate, high calories snacks had been a problem in the past. According to the QMRP, the client buys sodas when he goes out to the volunteer site from his day program. The QMRP stated that the direct support staff had been trained on strategies in the BSP to enable them to assist the client in purchasing only nutritious snacks. The review of the BSP dated 10/24/09 on 6/18/10 at 1:40 p.m. revealed an objective which stated, "He will use the quarters appropriately 100% of the trials. The BSP further noted [Client #2] should not be allowed to build up huge quantities of quarters, food or drinks at home or his day program. According to the BSP, the should not be allowed to buy anything not on his diet. On 6/18/10 and 6/17/10, the client was observed with a bag snack which contained only high sugar foods. At the time of the survey, however, there was no evidence staff had received specific instruction on how to manage the client when he was observed with snacks that were not included in the list of foods allowed by his therapeutic diet.	W 193	Cross reference W159 #1	8/3/10
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.	W 240		

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W 240	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that the behavior support plan (BSP) identified interventions to implemented by staff to support independence for selecting healthy snacks, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>1. Cross refer to W193. interview with the qualified mental retardation professional (QMRP) on 6/18/10 at 11:40 a.m. indicated that the client's behavior support plan (BSP) approved that he be able to purchase a healthy snack from the list provided by the consulting nutritionist. Additionally, she indicated that the direct support staff had been instructed to teach the client to purchase only nutritious snacks. According to the QMRP, the client purchased regular sodas and the snack cake while he was at his day program.</p> <p>On 6/18/10 at 1:40 p.m., continued review of Client #2 BSP (Cognitive plan) dated 10/24/09 revealed a section was entitled, "Quarters). The background notes revealed the client had a preoccupation of "having quarters on his person." The BSP revealed that numerous plans and standard procedures had been ineffective, due partly to their complicated procedures, the need for absolute consistency of all involved, and the client's overwhelming compulsion with quarters, as manifested by intense, persistent, and unyielding begging, borrowing, refusing to cooperate, tantruming and pestering. The BSP further noted: " He has often manipulated new staff or any staff who have attempted to develop</p>	W 240	<p>Cross reference W159 #1</p>	8/3/10
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CENTERS FOR MEDICARE & MEDICAID SERVICES**

**PRINTED: 07/07/2010
FORM APPROVED
OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3818 ALBERMARLE STREET NW WASHINGTON, DC 20008		
(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 240	Continued From page 11 money or food related plans for him. This plan is needed because in the past, this has caused trouble. He should not be allowed to buy anything not on his diet"	W 240			
W 249	At the time of the survey, however, there was no evidence that Client #2's BSP outlined specifically what measures staff should implement to prevent the client from purchasing food not allowed on his diet, or measure staff should implement if the client was observed with these foods when was picked up from his day program. 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. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of three clients in the sample. (Client 2) The finding includes: Cross refer to W159. The facility failed to ensure interventions identified in Client #2's behavior support plan were consistently implemented as evidenced below.	W 249	Cross reference W159 #1	8/3/10	

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W 249	<p>Continued From page 12</p> <p>On 6/16/10 at 12:15 p.m., Client #2 was observed seated at a table at his day program holding a plastic bag which contained 2 Ho Ho chocolate cake rolls, a 6.75 ounce Hi C box drink, and a 16 ounce regular Coke. The case manager indicated that the client brings these almost every day. On 6/17/10 at 6:45 a.m., Client #2 was observed in the kitchen of the group home with a plastic container in which there were a sealed packet of 2 Ho Ho cholate creme-filled cakes and a 6.75 ounce Hi C box drink.</p> <p>Interview with the QMRP on 6/18/10 at 11:55 a.m., indicated that Client #2's behavior support plan (BSP) approved that he be able to purchase a healthy snack from the list provided by the consulting nutritionist. According to the QMRP, the client purchased regular sodas and the snack cake while he was at his day program.</p> <p>On 6/18/10 at 12:17 p.m., review of Client #2 's BSP dated 10/24/09 revealed, "He should not be allowed to buy anything not on his diet." At the time of the survey, there was no evidence that Client #2 was being provided continuous active treatment to encourage him to buy those food allowed on his therapeutic diet, in accordance with his approved BSP.</p>	W 249		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by:</p>	W 263	<p>The QMRP will ensure that a written informed consent of all Clients, from family or medical guardian is obtained before sedation for a medical procedure.</p>	7/19/10

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W 263	<p>Continued From page 13</p> <p>Based on staff interview and record review, the facility failed to secure consent prior to sedating a client for medical treatment for one of three sampled clients. [Client #3]</p> <p>The finding includes:</p> <p>Record review on 6/17/2010, at 2:40 p.m. revealed Client #3 went for a dental assessment on 9/8/2009, but was not able to complete the assessment due to his maladaptive behavior. The 9/2009 assessment further recommended that Client #3 be sedated for his next appointment at a later date.</p> <p>Interview with the registered nurse (RN) and the qualified mental retardation professional (QMRP) on 6/17/2010 at 4:10 p.m. revealed Client #3 eventually saw the dentist on 4/8/2010 and was sedated so that he could maintain the appointment. Further record review on the same day at approximately 4:15 p.m. revealed Client #3's medication administration record (MAR) confirmed he received 2mg of Ativan as a measure of sedation for his 4/8/2010 dental appointment.</p> <p>Interview and additional record review with the facility's qualified mental retardation professional (QMRP) on 6/17/2010 at approximately 4:30 p.m. revealed a signed consent for the 4/8/2010 sedation was garnered from the legal guardian on 4/8/2010; one day after Client #3 was sedated for his dental appointment.</p> <p>The facility failed to ensure consent was obtained prior to sedating a client for a medical appointment.</p>	W 263		
W 331	483.480(c) NURSING SERVICES	W 331		

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W 331	<p>Continued From page 14</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of one of the three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>The facility's nursing services failed to develop an effective protocol to accurately monitor stools for one client who were prescribed stool softeners to prevent constipation, as follows:</p> <p>Observation of the medication administration on 6/18/10 at 8:15 a.m. revealed Client #1 was administered Polyethylene Glycol (Miralax) in 8 ounces of water. Interview with the Trained Medication Aide revealed the client received the medication to prevent constipation.</p> <p>Review of stool records to determine the effectiveness of the medication revealed Client #1 had no stools documented on 5/1/10 through 5/5/10. It should be noted however, that 5/3/10, 5/4/10 and 5/5/10 on the 8 a.m. - 4 p.m. had the entry DP (day program). Review of the administration record reveal client was administered a laxative, Milk of Magnesia 400 mg/5 ml. (30 cc po QD, as needed for constipation, if no BM in 3 days. The MAR revealed that the MOM was effective.</p> <p>Interview with the primary registered nurse (RN) on 6/18/10 at 1:15 p.m. indicated that it was</p>	W 331	<p>QMRP will send a Bowel Movement Chart to the day program daily to monitor bowel movements accurately during the day. The primary nurse and QMRP will monitor Bowel Movement Chart on a weekly basis. Medication Nurse will review Bowel Movement Chart daily.</p>	7/19/10
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W 331	Continued From page 15 unlikely that Client #1 had not had a stool in 5 days, however the MOM had been administered to ensure that the client did not become extremely constipated. Further interview with the nurse, however, revealed that a system had not been implemented to monitor stools the client may have at his day program. It was also noted, that the stool records for 4/10, 5/10, and 6/10 for weekdays had entries of "DP" (day program) or were left blank. At the time of the survey, there was no evidence that the facility had developed a system to ensure stool monitoring in all setting in order to determine the effectiveness of Client #1 prescribed Miralax.	W 331			
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of three clients in the sample (Client # 3) The findings include: Observation 6/16/2010 at approximately 4:20 p.m. revealed, Client #3 's teeth were disjointed and discolored. Record review on 6/17/2010 at 2:30 p.m. revealed the following dental treatment history:	W 356	The nursing staff and QMRP will monitor dental and appointments records to ensure that comprehensive dental treatment services will be provided in a timely manner as recommended by the primary care physician and dentist.	7/18/10	

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W 356	<p>Continued From page 16</p> <p>a. 9/8/2009 - Findings: patient highly aggressive today. Examination reveals moderate to heavy calculus deposits. Recommendations: patient needs full mouth scaling. Please sedate this patient before the next appointment. Return appointment date: 11/30/2009</p> <p>b. 11/30/2009 - Dental consult sheet on file, but there was no evidence this appointment was kept.</p> <p>c. 2/2/2010 - Dental consult sheet on file, but there was no evidence this appointment was kept.</p> <p>d. 4/6/2010 - Findings: oral examination reveals heavy calculus deposits... Adult prophylaxis and polishing. Recommendations: patient needs scaling, will submit to insurance for authorization and will call to schedule and once authorization is returned. Return appointment date: will call [to schedule]</p> <p>e. 4/8/2010 - Findings: patient unable to follow commands or sit still to complete x-rays needed for medical request for x-rays ... for scaling.</p> <p>Interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/17/2010 at 3:48 p.m. confirmed there was no documented evidence to explain why the 11/30/2009 and the 2/2/2010 dental appointments were missed. Upon further interview, the QMRP added that Client #3 could not attend his 2/2/2010 dental appointment because she was not able to secure consent in time for him to keep that appointment. Because of that, the appointment had to be pushed back. Client #3's oral health degraded from moderate to heavy calculus deposits to heavy calculus deposits between the dates of 9/8/2009 and 4/6/2009. The additional</p>	W 356			

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W 356	Continued From page 17 treatment of scaling that was attempted on 4/8/2009 was not completed due to Client #3 's non-compliant behavior.	W 356		
W 448	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that ensured problems with evacuation drills were investigated and addressed.</p> <p>The findings include:</p> <p>On 6/16/2010, beginning at 11:24 a.m., the facility's evacuation drill records were reviewed for the period 5/7/2009 - 6/16/2010. During the 12-month period, direct support staff documented that Client #2 was uncooperative on 9 out of 14 drills that were conducted during the 4:00 p.m. - 12 midnight shift, as follows:</p> <ol style="list-style-type: none"> 1. Client #2 "refused to get out of bed" on 5/28/2009 at 7:30 p.m., on 6/21/2009, at 7:40 p.m., on 7/23/2009, at 7:45 p.m., and on 8/24/2009, 8:15 p.m. 2. Staff documented that Client #2 "refused to move" on 10/24/2009, at 6:35 p.m., on 12/12/2009, at 6:25 p.m., and on 2/3/2010, at 6:50 p.m. 3. On 3/19/2010, at 6:00 p.m., staff wrote Client 	W 448	<p>QMRP will coordinate a meeting with Client #2's psychologist to discuss intervention methods for failure to evacuate during fire drills and revise his Behavior Support Plan to address this issue. The QMRP will review all fire drills on a monthly basis.</p>	8/3/10

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W 448	<p>Continued From page 18</p> <p>#2 "proved difficulty <sic> to get to act accordingly." On 6/4/2010, at 6:17 p.m., staff documented that he "refused to cooperate."</p> <p>Further review of the facility's drill reports, including the 9 cited above, failed to show evidence that the forms had been reviewed or that the client's refusals had been investigated.</p> <p>On 6/16/2010, at 12:11 p.m., interview with the qualified mental retardation professional (QMRP), who also served as residence manager, revealed that none of her staff had brought Client #2's refusals to cooperate during fire drills to her attention. She stated that original drill report forms were taken by a driver to the provider agency's corporate office. She thought the report forms were reviewed by either a night manager or the administrator at the office and were then returned to the facility to be filed. Upon review of the report forms on file, the QMRP acknowledged that said reviews had not been documented on the forms. She agreed to seek additional information from the main office.</p> <p>At approximately 12:16 p.m., further interview with the QMRP revealed that Client #2 had a behavior support plan (BSP), dated 10/24/09, that addressed refusing to cooperate with staff requests, including wearing a CPAP machine at night and taking his medications. The BSP, however, did not address fire drills. The QMRP further acknowledged that his refusals to cooperate during fire drills had not been investigated, to date.</p> <p>On 6/16/2010, at 12:41 p.m., the QMRP stated that she had just spoken by telephone with the facility's former house manager. He reportedly</p>	W 448			

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W 448	Continued From page 19 told her that it was the night manager who reviewed fire drill report forms. The former house manager further indicated that Client #2 previously had a BSP developed to address refusals to cooperate during fire drills. The QMRP, however, stated that the BSP in question may have "expired." She stated that she would have the psychologist reassess Client #2. On 6/18/2010, at approximately 12:55 p.m., review of the "Fire Drill Procedures" (not dated) revealed the following: "Fire drill reports are due on or before the 15th of the month to the Director." At 2:54 p.m., the QMRP stated that the "Director" referred to in the policy was the agency's Program Director. No additional information was presented before the survey ended on 6/18/2010. There was no evidence that the facility investigated problems identified during fire drills.	W 448		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based observation, interview and record review, facility failed to ensure the provision of a well balanced, modified diet for one of three clients in the sample. (Client #2) The findings include: 1. The facility failed to closely monitor Client #2's nutritional intake to ensure that it met his health needs, as evidenced below.	W 460		
			1. Cross reference W159 #2	8/3/10

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W 460	Continued From page 20 On 6/16/10 at approximately 5:25 p.m., Client #2 was observed eating a high calorie, sweet snack, including a 16 oz Coke. He was observed to drink another Coke at dinner, and to only eat approximately 10 % of his dinner meal. Interview with direct support staff during the survey, revealed that at times the client did not eat well. Interview with the qualified mental retardation professional on 6/18/10 at 11:52 a.m. revealed the client may not eat with his housemates, but eats at least 80% of his food at most meals. Interview with day program staff revealed the client usually purchased a high sugar snack and a soda with his quarters from the group home for compliant behavior. On 6/18/10 at 1:32 p.m., the registered nurse (R.N.) indicated that the client had experienced a gradual weight loss as as recommended by the nutritionist and the primary care physician (PCP). Record review on 6/17/10 had revealed the client had a gradual weight loss of 7 pounds (146 pounds to 139 pounds from 12/09 to 5/10. On 6/18/10 at 12:14 p.m., review of a medical progress note dated 4/10/10 had revealed a weight loss trend. "Usually missing meals and in bedroom." On 5/28/10 the PCP noted that the weight loss was desirable, based on the 1500 calorie restriction and the client's ideal body weight (IBW) of 134 to 144 pounds) for his height of 5 feet. On 6/18/10 the nutritional assessments dated 11/09, 2/10, and 5/10 revealed the Client #2 continued to have a desirable weight loss, and was within his IBW for height. Accordingly, the	W 460			

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W 460	<p>Continued From page 21</p> <p>nutritionist indicated that the prescribed 1500 calorie, low sodium, mechanically soft diet was adequate to achieve this goal. Further review of the nutritional assessments revealed "He likes juice and sodas." Nutritional recommendations included the following: "Provide low calorie snack list... Offer water with meals and snacks... Continue to review nutrition regime with day placement." At the time of the survey, however, there was no evidence that the client's calories consumed had been adequately monitored to ensure that he received a nutritionally balanced diet. Additionally, there was no evidence that the nutritionist had provided ongoing training to the client to encourage his dietary compliance.</p> <p>2. The facility failed to monitor Client #2's nutritional intake to address his marginal hemoglobin level, as evidenced below:</p> <p>Interview with day program staff on 6/16/10 and group home staff on 6/17/10 and 6/18/10 revealed that client preferred "empty calorie snack" instead of nutritious snack. Staff also indicated that the client did not eat all of his food during meals at times.</p> <p>On 6/18/10 at 12:15 p.m., the record review revealed Client #2 had a gradual weight loss, reported as "desirable", however, his hemoglobin continued to be marginal, after multiple testing, as follow:</p> <p>10/22/09 - 11.2 gm (reference range 12.5 gm to 17.00 gm) 2/1/10 - 12.3 gm 5/4/10 - 10.9 gm 5/28/10 - 12.1 gm 6/2/10 - 11.2 gm.</p>	W 460	<p>2. Primary Care Physician will review hemoglobin levels and diet of Client #2 to determine if there is a correlation between the two. A consult will be made with the nutritionist.</p>	8/31/10	

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W 460	Continued From page 22 On 8/18/10 at 11:12 a.m., review of Client #2's nutritional assessments dated 11/08, 2/10, and 5/10 had revealed no evidence the abnormal hemoglobin had been addressed. Although the Client #2's hemoglobin had been medically monitored for possible changes, at the time of the survey, there was no evidence that nutritional intake had been assessed to determine if there was a possible correlation between the nutritional quality of his diet and his marginal hemoglobin level.	W 460		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed. The findings include: Observation on the evening of 8/16/2010 at 5:30 p.m. revealed Client #3 was served two small potatoes that were approximately two and 1/2 (2.5) inches round as part of his meal. Both potatoes were cut in half by the staff and Client #3 was served all four pieces whole. Record review on 8/17/2010 at 2:52 p.m. revealed, Client #3's physician's orders prescribed he receive a "regular chopped" diet. Interview with the facility's qualified mental retardation professional (QMRP) on 8/18/2010 at approximately 2:30 p.m. confirmed Client #3 did	W 474	Cross reference W192 #1	8/3/10

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

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OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3816 ALBERMARLE STREET NW WASHINGTON, DC 20008
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W 474	Continued From page 23 not receive his correct food texture during dinner on the evening of 6/16/2010. The QMRP and the facility's nurse indicated they would work to address that oversight and re-train staff immediately. The facility failed to ensure Client #3 was provided a "chopped" diet as prescribed. [See also W192]	W 474		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
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1 000 INITIAL COMMENTS

A licensure survey was conducted from 6/16/2010 through 6/16/2010. A sample of three residents was selected from a population of six men with varying degrees of intellectual and/or developmental disabilities.

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

1 000

1 082 3503.10 BEDROOMS AND BATHROOMS

Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.

This Statute is not met as evidenced by:
Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to equip all bathrooms used by residents with paper cups.

The findings include:

1. On 6/16/2010, at 3:17 p.m., there were no paper cups in the paper cup dispenser mounted on the wall in the restroom located on the third floor.
2. At 3:26 p.m., there were no paper cups in the paper cup dispenser mounted on the wall in the restroom located on the second floor.
3. At approximately 3:45 p.m., there were no

1 082

QMRP will equip all bathrooms with paper cups. The QMRP will equip all bathrooms with toilet tissue, paper towels, cup dispenser, soap, and mirror.

7/19/10

Health Regulation Administration

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

Constantine A. Reese
Program Director

(X6) DATE

7/16/10

STATE FORM

DTXJ11

If continuation sheet of 31

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
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I 082 Continued From page 1
paper cups in the restroom located in the basement.

The qualified mental retardation professional, who also served as house manager, acknowledged that there were no cups available in any of the bathrooms in the facility.

I 082

I 090 3504.1 HOUSEKEEPING

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

This Statute is not met as evidenced by:
Based on observation and interview, the GHMRP maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for six of the six residents in the facility. (Residents #1, #2, #3, #4, #5 and #6)

The findings include:

Observation and interview with the facility's qualified mental retardation professional (QMRP), who also served as house manager, on 6/16/2010, beginning at 2:57 p.m. revealed the following:

Exterior:

1. The paint on the wooden trim on the exterior of the back porch was peeling.

Interior:

I 090

1. Wooden trim on the exterior of back porch will be repainted.

8/31/10

Health Regulation Administration

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1 090	<p>Continued From page 2</p> <p>2. Caulking around the top edge of the bathtub in the bathroom located on the second floor was cracked and/or marred by black mildew stains. [Note: A maintenance man came to the facility that afternoon and at 6:45 p.m., observation of the same bathtub revealed that the deficiency had been abated.]</p> <p>3. There were no blinds in the window facing the backyard within Resident #1's bedroom. [Note: A maintenance man came to the facility that afternoon and at 6:45 p.m., observation of the same window revealed that the deficiency had been abated.]</p> <p>4. The sofa table located in front of the fireplace in the living room was missing one of three decorative handles.</p> <p>The QMRP acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.</p>	1 090	<p>2. Top edge of the bathtub on second floor will be recaulked.</p> <p>3. Blinds will be placed in the window of Resident #1's bedroom.</p> <p>4. The sofa table's decorative handle will be replaced.</p>	<p>8/18/10</p> <p>6/18/10</p> <p>8/15/10</p>
1 109	<p>3504.16 HOUSEKEEPING</p> <p>Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her individual Habilitation Plan (IHP).</p> <p>This Statute is not met as evidenced by: Based on the environmental inspection, the group home for persons with mental retardation (GHMRP) failed to consistently label inconspicuously each item of clothing as belonging to a particular resident, for five of the six residents of the facility. (Residents #1, #2, #4, #5 and #6)</p>	1 109	<p>The facility's staff will label, inconspicuously each item of clothing for each Resident. QMRP will inspect wardrobe weekly to ensure that all items of clothing are labeled.</p>	<p>7/10/10</p>

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I 109	Continued From page 3 The findings include: 1. During the inspection of the environment on 6/16/2010, beginning at 2:57 p.m., there were several pairs of white, athletic socks observed in Resident #1's bedroom drawer that were without initials of any kind. The qualified mental retardation professional (QMRP), who was present at the time, stated that client did not share the bedroom with any of his peers. Mixed into the same drawer were socks marked with Resident #4's initials. 2. Continued inspection revealed that facility staff had not established an effective system to manage the residents' clothing. Residents #5 and #6 shared a bedroom. Inspection of their underwear drawers revealed an undershirt marked with Resident #5's initials was observed in Resident #6's drawer. Similarly, there were underpants with Residents #2 and #6 initials on them observed in Resident #5's drawer. The QMRP, who was present at the time, acknowledged the above-cited deficiencies.	I 109		
I 110	3504.17 HOUSEKEEPING Each GHMRP shall ensure that each resident's clothing is kept in good condition, laundered, and cleaned. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that residents' clothing was kept in good condition, for two of the six residents of the facility. (Residents #5 and #6)	I 110	The facility's staff will inspect each Resident's clothing daily to ensure that they are kept in good condition. QMRP will inspect wardrobe of each Resident weekly to ensure that all items of clothing are kept in good condition.	7/29/10

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I 110	Continued From page 4 The findings include: 1. On 6/16/2010, at 3:07 p.m., inspection of Resident #5's clothing inventory revealed an undershirt with a tattered collar and holes in the armpits. 2. On 6/16/2010, at 3:09 p.m., inspection of Resident #6's clothing inventory revealed three undershirts with tattered collars and holes in the armpits. The QMRP, who was present at the time, acknowledged the above-cited deficiencies.	I 110		
I 181	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) governing body failed to document a review of its policies and procedures annually. The finding includes: On 6/16/2010, at 1:37 p.m., review of the policy and procedure manual that was maintained in the home revealed a review date 5/21/2008. The qualified mental retardation professional telephoned their corporate office and at 1:50 p.m., she stated that she had just been informed that the policies had been reviewed again since 5/21/2008; however, no date was offered. She acknowledged that there was no documentation available to verify an annual review of the	I 181	In the future, company policies and procedures will be reviewed on an annual basis.	7/19/10

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I 161 Continued From page 5
policies. No additional information was presented before the survey ended on 6/18/2010.

I 161

I 180 3508.1 ADMINISTRATIVE SUPPORT
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 GHMRP failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for two of three residents in the sample.
(Residents #2 and #3)

I 180

The findings include:

1. The GHMRP failed to coordinate services to ensure Resident #2's behavior support plan (BSP) was consistently implemented, as evidenced below:

On 6/16/10 at 12:15 p.m., Resident #2 was observed seated at a table at his day program holding a plastic bag, which contained 2 Ho Ho chocolate cake rolls, a 6.75 ounce Hi C box drink, and a 16 ounce Regular Coke. The case manager indicated that the resident brings these almost every day. At 12:20 p.m., the resident received a ground meal (chicken nuggets, cauliflower medley, steak fries) and milk, which he consumed approximately 80%.

Interview with the case manager on 6/16/10 at 12:25 p.m., revealed the Resident #2 was prescribed a 1500 calorie, soft diet. The case manager revealed that although nutritious and

1. Cross reference W159 #1

8/3/10

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I 180	Continued From page 6 low calories snacks were available at the day program, it had difficult had to get the resident to select them, because he seemed to prefer concentrated sweets, such as cakes and regular sodas. The case manager stated that the resident's selection of inappropriate snacks had been discussed at his quarterly meeting on 2/5/10, however, the meeting had not resulted in a sustained change in the nutritional quality of the resident's snack selections. On 6/16/10, at 3:52 p.m., Resident #2 was observed at the dining table of his group home eating a Ho Ho creme filled chocolate cake roll and drinking a 16 ounce Coke. Observation of the dinner meal at 5:25 p.m. revealed the resident drank another 16 ounce Coke, however only ate approximately 10% of his meal. On 6/17/10 at 8:45 a.m., Resident #2 was observed in the kitchen of the group home with a plastic container in which there were 2 Ho Ho chocolate creme-filled cakes and a 6.75 ounce Hi C box drink. (A partial case of Hi C was observed in the basement storage room.) The resident was then observed asking for a soda. When staff told him there was no soda, he began to persistently request quarters. Interview with the QMRP on 6/16/10 at 11:40 a.m. acknowledged that Resident #2's selection of inappropriate, high calories snacks had been a problem in the past. The QMRP stated that the resident buys the sodas when he goes out to the volunteer site from his day program. She referenced the interdisciplinary discussion concerning this issue at the resident's 2/1/10 quarterly meeting. According to the QMRP, the resident's behavior support plan (BSP) had been approved to allow him to purchase a healthy	I 180		

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I 180 Continued From page 7

snack. The QMRP stated that the resident only received snacks approved by the nutritionist from the group home. Additionally, she indicated that the direct support staff had been instructed to teach the resident to purchase only nutritious snacks.

On 6/18/10 at 12:17 p.m., review of Resident #2 BSP (Cognitive plan) dated 10/24/09 revealed a section entitled, "Quarters." The background notes revealed the resident had a preoccupation of "having quarters on his person." The BSP also revealed that "numerous plans and standard procedures had been ineffective, due partly to their complicated procedures, the need for absolute consistency of all involved, and the resident's overwhelming compulsion with quarters, as manifested by intense, persistent, and unyielding begging, borrowing, refusing to cooperate, tantrumming and pestering."

Continued review of the BSP on 6/18/10 at 12:22 p.m., revealed that Resident #2's BSP included an objective that he "will use the quarters appropriately 100% of the trials." The BSP further noted: " he has often manipulated new staff or any staff who have attempted to develop money or food related plans for him. [Resident #2] should not be allowed to build up huge quantities of quarters, food or drinks at home or his day program. This plan is needed because in the past this has caused trouble. Ha should not be allowed to buy anything not on his diet

At the time of the survey, there was no evidence the QMRP had coordinated with Resident #2's the interdisciplinary team, including the day program to develop effective strategies to reduce his purchasing of empty calorie snack foods.

I 180

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I 180	<p>Continued From page 9</p> <p>trained to implement walking/ambulation protocols and mealtime feeding protocols for Resident #3. [See W192]</p> <p>5. The QMRP failed to secure consent prior to sedating a Resident #3 for medical treatment. [See W263]</p> <p>6. The QMRP failed to ensure the residential staff provided meals for Resident #3 in the form and texture as prescribed. [See W474]</p>	I 180	<p>5. Cross reference W263</p> <p>6. Cross reference W192 #1</p>	<p>7/19/10</p> <p>8/3/10</p>
I 186	<p>3508.5(c) ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have an organization chart that shows the following:</p> <p>(c) The categories and numbers of supportive and direct care staff; and...</p> <p>This Statute is not met as evidenced by: Based on review of the organizational chart presented, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that the organizational chart showed the numbers of supportive staff.</p> <p>The finding includes:</p> <p>On 6/16/2010, at approximately 2:15 p.m., review of the facility's Organizational Chart (not dated) revealed that it did not indicate the number of direct support staff, number of medication nurses and/or the number of drivers providing support services to the six residents of the GHMRP. A moment later, the qualified mental retardation professional, who also served as house manager, stated that they had 13 direct support staff, 2 medication nurses and an unknown number of drivers. Upon review of the Organizational Chart,</p>	I 186		

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I 188	Continued From page 10 she acknowledged that the numbers of those aforementioned supportive staff were not indicated. No additional information was presented before the survey ended on 6/18/2010.	I 188		
I 208	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for 1 out of 13 employees, 1 out of 2 medication nurses, and 4 out of 11 professional consultants.</p> <p>The findings include:</p> <p>On 6/16/2010, at 2:30 p.m., the qualified mental retardation professional (QMRP) presented personnel records for all employees and consultants. Beginning at 4:00 p.m., review of personnel records revealed no evidence of current health certificates for the following:</p> <ul style="list-style-type: none"> - 1 of the 13 direct support staff (S1); 	I 208	<p>The physician's certification records for S1, medication nurse and consultants will be obtained and filed. In the future, QMRP will ensure that each employee provides evidence of a physician's certification.</p>	7/29/10

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I 208	<p>Continued From page 11</p> <ul style="list-style-type: none"> - 1 of the 2 medication nurses (N1); and, - the following consultants: primary care physician, speech pathologist, occupational therapist, psychologist, behavior specialist and physical therapist. <p>On 6/17/2010, at 1:00 p.m., the QMRP presented evidence of current health certificates for the psychologist and physical therapist. No additional information, however, was presented before the survey ended on the afternoon of 6/18/2010; therefore, compliance could not be verified for the 1 direct support staff, 1 medication nurse and 4 health care consultants (primary care physician, behavior specialist, speech therapist and occupational therapist).</p> <p>This is a repeat deficiency.</p> <hr/> <p>Previously, the licensure deficiency report dated 2/20/2009, included the following:</p> <p>"Interview with the house manager and review of the personnel records on February 20, 2009, beginning at 2:42 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for 9 of 13 direct care staff (Staffs #A, #C, #E, #F, #G, #H, #K, #L, and #M)."</p> <p>It should be noted that Staff H in the 2/20/2009 survey was the same employee (S1) who was without evidence of a current health certificate in this survey (6/18/2010).</p>	I 208		

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I 222 Continued From page 12
I 222 3510.3 STAFF TRAINING

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the GHMRP failed to ensure continuing training program for all personnel to address the needs of two of three residents in the sample. (Residents #2, and #3)

The findings includes:

I. The GHMRP failed to ensure all staff was competent in implementing the modified food texture and ambulation protocols Resident #3.

A. [Cross Reference to Federal Deficiency Report - W474]

Resident #3 was not provided a "chopped" textured meal on the evening of 6/17/2010. His two and a half (2 1/2) inch round potatoes were cut in half and served whole. The observation was later confirmed via interviews with the GHMRP's qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/18/2010. The QMRP indicated she would address the oversight immediately.

B. Observation on 6/16/2010 at approximately 4:15 p.m., revealed Resident #3's one-to-one staff (evening shift) provided ambulation assistance by standing slightly behind him and supporting his waist and one arm as he walked. Observation on 6/17/2010 at approximately 11:40 a.m. revealed Resident #3's one-to-one staff (day shift) provided support by placing his left arm underneath Resident #3's right arm to provide

I 222		
I 222	A. Cross reference W192 #1	8/3/10
I 222	B. Cross reference W192 #2	8/3/10

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I 222	<p>Continued From page 13</p> <p>lift and support as they walked to the bathroom. That same technique was again used by the staff when they returned from the bathroom and returned to his seat. On both occasions, Resident #3 was observed trying to lean forward as he ambulated to his destination. Both staff provided direct physical assistance to straighten him out until he reached his destination.</p> <p>Record review on 6/17/2010 at 2:28 p.m. revealed part of Resident #3 's walking protocol dated 7/18/2008 provided the following interventions:</p> <p>(1) Staff should provide [Resident #3] with physical assistance by placing their arm under his waist by holding on to his gait belt. (2) During ambulation, staff should stand to the side of [Resident #3]. (3) Staff should provide verbal prompts to [Resident #3] so he can walk upright as much as possible. (4) When [Resident #3] begins to lean forward or walk too fast, staff should have him completely stop walking then start again.</p> <p>The walking protocol confirmed that staff failed to use the gait belt as prescribed; failed to consistently stand by the " side " of the resident during ambulation; failed to provide verbal prompts to encourage him to walk upright as much as possible; and failed to ensure they stopped walking whenever Resident #3 attempted to lean forward when ambulating.</p> <p>Interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/18/2010 at 3:58 p.m. confirmed there has been no staff training from the physical therapist to address the interventions outlined in</p>	I 222		

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I 222	<p>Continued From page 14</p> <p>the walking program over the past year. Both the QMRP and the RN indicated the lack of staff training and oversight by the PT is probably the cause for the staff not consistently implementing the walking protocol.</p> <p>II. The GHMRP's staff failed to demonstrate the skills and techniques necessary to implement each resident's behavior support plan (BSP), for Residents #2 .</p> <p>[Cross Reference to Federal Deficiency Report - W159] On 6/16/10 (12:15 p.m.) and 6/17/10 (8:32 a.m.), Resident #2 was observed holding a bag snack with contained only high sugar foods. On 6/16/10 at 3:52 p.m., he was observed eating the aforementioned snack.</p> <p>Interview with the QMRP on 6/18/10 at 11:40 a.m. acknowledged that Resident #2 selecting inappropriate, high calories snacks had been a problem in the past. According to the QMRP, the resident buys sodas when he goes out to the volunteer site from his day program. The QMRP stated that the direct support staff had been trained on strategies in the BSP to enable them to assist the resident in purchasing only nutritious snacks.</p> <p>The review of the BSP dated 10/24/09 on 6/18/10 at 1:40 p.m. revealed an objective which stated, "He will use the quarters appropriately 100% of the trials. The BSP further noted [Resident #2] should not be allowed to build up huge quantities of quarters, food or drinks at home or his day program. According to the BSP, the should not be allowed to buy anything not on his diet. On 6/18/10 and 6/17/10, the resident was observed with a bag snack which contained only high sugar foods.</p>	I 222	<p>Cross reference W159</p> <p>8/3/10</p>

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| 222 | Continued From page 15

At the time of the survey, however, there was no evidence staff had received specific instruction on how to manage the resident when he was observed with snacks that were not included in the list of foods allowed by his therapeutic diet.

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| 372 | 3519.3 EMERGENCIES

Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.

This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.

The findings include:

1. On 6/16/2010, at 5:30 p.m., there was no list of emergency contact numbers posted near the two telephones located in the basement. There were several lists of agency employees posted near the telephone on the desk used by the qualified mental retardation professional (QMRP). However, after further review of said lists, the QMRP acknowledged that there was no list identified as an "Emergency" list and that she could not locate any reference to emergency 911.
2. On 6/16/2010, at 6:45 p.m., there was no list of emergency contact numbers posted near the telephone located in the kitchen. This was

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QMRP will post a list of emergency phone numbers by each telephone in the facility. The QMRP will ensure that an emergency list is visible near every telephones.

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I 372	Continued From page 16 acknowledged by the QMRP.	I 372			
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of six residents in the facility. (Resident #1) The finding includes: On 6/16/2010, at approximately 11:30 a.m., interview with Resident #1's day program nurse revealed that the resident had been hospitalized a few months prior to the survey. A pre-survey review of incidents that were reported to DOH/HRLA had not, however, revealed any incidents involving Resident #1. The qualified mental retardation professional (QMRP) was interviewed in the facility on 6/16/2010, beginning at approximately 2:00 p.m.	I 379	The QMRP will notify the Department of Health of any unusual incidents or events within twenty-four hours.	7/19/10	

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1379	<p>Continued From page 17</p> <p>She confirmed that Resident #1 had spent 2 weeks in a hospital psychiatric ward in 4/2010. She described how the resident's appetite was sporadic for several months prior to his hospitalization. Physicians reportedly could not determine the cause(s) of what she described as a steady, chronic decline in his mental status. The QMRP further indicated that the resident's medication regimen had been altered during that period. She described the resident as trembling, shaking and showing other signs of distress. Eventually, the resident stopped eating altogether. When the facility informed the psychiatrist that he went without eating for 3 or 4 days, the doctor recommended that they admit him to a hospital to be stabilized.</p> <p>The QMRP acknowledged that the facility had not prepared a written incident report for the hospitalization. Another government official reportedly told her that an incident report was not necessary because a physician had recommended the hospitalization. The QMRP further acknowledged that DOH/HRLA was not notified by telephone nor had the facility sent written notification.</p> <p>On 6/16/2010, beginning at 2:35 p.m., review of the facility's Incident Management System policy revealed that "Unplanned hospitalization or ER visit for treatment of a chronic physical or mental illness or condition" was included in a list of "Reportable Incidents." The policy also included the following on page 14: "incident report forms must be completed for all reportable incidents on the Incident Report Form. These incident reports (to include all internal investigative documents) are to be maintained at the provider agency" shall be made available to all surveyors upon request."</p>
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I 379	Continued From page 18 It should be noted that upon further inquiry, the QMRP stated that Resident #1's hospitalization was not investigated. She also indicated that to date, the facility's medical team had not determined what precipitated his change in condition and eventual hospitalization.	I 379		
I 399	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (l) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHMRP, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is: Review of the personnel records on 6/16/2010, beginning at 4:00 p.m., revealed that a current license/professional certification was not available	I 399	A copy of the credentials for the person providing Speech Language Therapy will be obtained and filed. The QMRP will ensure that all qualified professional staff has a copy of professional credentials in their file.	7/31/10

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I 399	<p>Continued From page 19</p> <p>for the Speech Language Therapist and/or her assistant.</p> <p>At approximately 5:15 p.m., the qualified mental retardation professional confirmed that the license/ professional credentialing for the Speech Language Therapist and/or her assistant were not available for review. No additional information was presented before the survey ended two days later.</p> <p>On 6/21/2010, beginning at 3:55 p.m., a post-survey search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise</p>	I 399		

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I 399	Continued From page 20 provided in this chapter.	I 399		
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure timely treatment services for four of the six residents living in the group home..(Residents #1, #2, and #3)</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure timely treatment services for the maintenance of dental health of Resident # 3, as evidenced below:</p> <p>Observation 6/16/2010 at approximately 4:20 p.m. revealed, Resident #3 's teeth were disjointed and discolored. Record review on 6/17/2010 at 2:30 p.m. revealed the following dental treatment history:</p> <p>(a) 8/8/2009 - Findings: patient highly aggressive today. Examination reveals moderate to heavy calculus deposits. Recommendations: patient needs full mouth scaling. Please sedate this patient before the next appointment. Return appointment date: 11/30/2009</p> <p>(b) 11/30/2009 - Dental consult sheet on file, but there was no evidence this appointment was kept.</p>	I 401	<p>1. Cross reference W358</p>	7/18/10

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1401	Continued From page 21 (c) 2/2/2010 - Dental consult sheet on file, but there was no evidence this appointment was kept. (d) 4/6/2010 - Findings: oral examination reveals heavy calculus deposits... Adult prophylaxis and polishing. Recommendations: patient needs scaling, will submit to insurance for authorization and will call to schedule and once authorization is returned. Return appointment date: will call [to schedule] (e) 4/8/2010 - Findings: patient unable to follow commands or sit still to complete x-rays needed for medical request for x-rays ... for scaling. Interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) on 6/17/2010 at 3:48 p.m. confirmed there was no documented evidence to explain why the 11/30/2009 and the 2/2/2010 dental appointments were missed. Upon further interview, the QMRP added that Resident #3 could not attend his 2/2/2010 dental appointment because she was not able to secure consent in time for him to keep that appointment. Because of that, the appointment had to be pushed back. Resident #3's oral health degraded from moderate to heavy calculus deposits to heavy calculus deposits between the dates of 8/8/2008 and 4/6/2009. The additional treatment of scaling that was attempted on 4/8/2009 was not completed due to Resident #3's non-compliant behavior. The GHMRP failed to ensure Resident #3 received timely dental services. 2. The GHMRP failed to ensure nursing services were provided in accordance with the needs of	1401	2. Cross reference W331	7/19/10

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I 401	<p>Continued From page 22</p> <p>Resident #1, as evidenced below:</p> <p>The GHMRP's nursing services failed to develop an effective protocol to accurately monitor stools for one resident who were prescribed stool softeners to prevent constipation.</p> <p>Observation of the medication administration on 6/18/10 at 8:15 a.m. revealed Resident #1 was administered Polyethylene Glycol (Miralax) in 8 ounces of water. Interview with the Trained Medication Aide revealed the resident received the medication to prevent constipation.</p> <p>Review of stool records to determine the effectiveness of the medication revealed Resident #1 had no stools documented on 5/1/10 through 5/5/10. It should be noted however, that 5/3/10, 5/4/10 and 5/5/10 on the 8 a.m. - 4 p.m. had the entry DP (day program). Review of the administration record reveal resident was administered a laxative, Milk of Magnesia 400 mg/5 ml. (30 cc po QD, as needed for constipation, if no BM in 3 days. The MAR revealed that the MOM was effective.</p> <p>Interview with the primary registered nurse (RN) on 6/18/10 at 1:15 p.m. indicated that it was unlikely that Resident #1 had not had a stool in 5 days, however the MOM had been administered to ensure that the resident did not become extremely constipated. Further interview with the nurse, however, revealed that a system had not been implemented to monitor stools the resident may have at his day program. It was also noted, that the stool records for 4/10, 5/10, and 6/10 for weekdays had entries of "DP" (day program) or were left blank.</p> <p>At the time of the survey, there was no evidence</p>	I 401		

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I 401	Continued From page 23 that the GHMRP had developed a system to ensure stool monitoring in all setting in order to determine the effectiveness of Resident #1 prescribed Miralax. 3. The GHMRP failed to ensure the provision of a well balanced, modified diet for Resident #2, as evidenced below: A. The GHMRP failed to closely monitor Resident #2's nutritional intake to ensure that it met his health needs. On 8/16/10 at 3:52 p.m., Resident #2 was observed eating a high calorie, sweet snack, including a 16 oz Coke. He was observed to drink another Coke at dinner, and to only eat approximately 10% of his dinner meal. Interview with direct support staff during the survey, revealed that at times the resident did not eat well. Interview with the qualified mental retardation professional on 8/18/10 at 11:52 a.m. revealed the resident may not eat with his housemates, but eats at least 80% of his food at most meals. Interview with day program staff revealed the resident usually purchased a high sugar snack and a soda with his quarters from the group home for compliant behavior. On 8/18/10 at 1:32 p.m., the registered nurse (R.N.) indicated that the resident had experienced a gradual weight loss as as recommended by the nutritionist and the primary care physician (PCP). Record review on 6/17/10 had revealed the resident had a gradual weight loss of 7 pounds (148 pounds to 139 pounds from 12/09 to 5/10. On 6/18/10 at 12:14 p.m., review of a medical	I 401	3. Cross reference W159 #1	8/3/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	Continued From page 24 progress note dated 4/10/10 had revealed a weight loss trend. "Usually missing meals and in bedroom." On 5/28/10 the PCP noted that the weight loss was desirable, based on the 1500 calorie restriction and the resident's ideal body weight (IBW) of 134 to 144 pounds) for his height of 5 feet. On 6/18/10 the nutritional assessments dated 11/09, 2/10, and 5/10 revealed the Resident #2 continued to have a desirable weight loss, and was within his IBW for height. Accordingly, the nutritionist indicated that the prescribed 1500 calorie, low sodium, mechanically soft diet was adequate to achieve this goal. Further review of the nutritional assessments revealed "He likes juice and sodas." Nutritional recommendations included the following: "Provide low calorie snack list...Offer water with meals and snacks... Continue to review nutrition regime with day placement." At the time of the survey, however, there was no evidence that the resident's calories consumed had been adequately monitored to ensure that he received a nutritionally balanced diet. Additionally, there was no evidence that the nutritionist had provided ongoing training to the resident to encourage his dietary compliance. 4. The GHMRP failed to monitor Resident #2's nutritional intake to address his marginal hemoglobin level. Interview with day program staff on 6/16/10 and group home staff on 6/17/10 and 6/18/10 revealed that resident preferred "empty calorie snack" instead of nutritious snack. Staff also indicated that the resident did not eat all of his food during meals at times.	1401	4. Cross reference W159 #1	8/3/10

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I 401	<p>Continued From page 25</p> <p>On 6/18/10 at 12:15 p.m., the record review revealed Resident #2 had a gradual weight loss, reported as "desirable", however, his hemoglobin continued to be marginal, after multiple testing, as follow:</p> <p>10/22/09 - 11.2 gm (reference range 12.5 gm to 17.00 gm) 2/1/10 - 12.3 gm 5/4/10 - 10.9 gm 5/28/10 - 12.1 gm 6/2/10 - 11.2 gm.</p> <p>On 6/18/10 at 11:12 a.m., review of Resident #2's nutritional assessments dated 11/09, 2/10, and 5/10 had revealed no evidence the abnormal hemoglobin had been addressed. Although the Resident #2's hemoglobin had been medically monitored for possible changes, at the time of the survey, there was no evidence that nutritional intake had been assessed to determine if there was a possible correlation between the nutritional quality of his diet and his marginal hemoglobin level.</p> <p>5. The GHMRP failed to ensure that the interdisciplinary team, including a qualified dietitian, physician, and the psychologist, determined how the use of food would be monitored as integral a part of a program to manage inappropriate behavior, Resident #2, as evidenced below:</p> <p>[Cross refer to Federal Deficiency Report - Citation W159]. On 6/16/10 (12:15 p.m.) and 6/17/10 (8:32 a.m.), Resident #2 was observed holding a snack which contained only high sugar foods. On 6/16/10 at 3:52 p.m., he was observed eating the aforementioned snack.</p>	I 401	<p>5. Cross reference W159 #2</p>	8/3/10

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		
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I 401	Continued From page 26 Interview with the qualified mental retardation professional (QMRP) on 6/18/10 at 12:37 p.m., indicated the resident had purchased the snacks while at his day program. Continued interview with the QMRP revealed that Resident #2's prescribed 1500 calorie diet permitted him to have only nutritious snacks, which were in accordance with his diet plan. According to the QMRP, the inclusion of the snacks was approved in the resident's behavior support plan dated 10/24/09. The QMRP, however, revealed that no written plan/strategies had been developed or implemented which incorporated food as a behavior reinforcer into the resident's 1500 calorie therapeutic diet. The review of the BSP dated 10/24/09 on 6/18/10 at 1:40 p.m. revealed an objective which stated, "He will use the quarters appropriately 100% of the trials. The BSP further noted [Resident #2] should not be allowed to build up huge quantities of quarters, food or drinks at home or his day program. According to the BSP, the should not be allowed to buy anything not on his diet. On 6/16/10 and 6/17/10, the resident was observed with a bag snack with contained only high sugar foods. At the time of the survey, however, there was no evidence a specific plan had been developed to integrate and monitor foods provided as reinforcers into the Resident #2's diet and behavior support plan.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.	I 422	Cross reference W159	8/3/10

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1422	<p>Continued From page 27</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>[Cross refer to Federal Deficiency Report - W159]. The GHMRP failed to ensure interventions identified in Resident #2's behavior support plan were consistently implemented as evidenced below:</p> <p>On 6/16/10 at 12:15 p.m., Resident #2 was observed seated at a table at his day program holding a plastic bag which contained 2 Ho Ho chocolate cake rolls, a 6.75 ounce Hi C box drink, and a 16 ounce regular Coke. The case manager indicated that the resident brings these almost every day. On 6/17/10 at 8:45 a.m., Resident #2 was observed in the kitchen of the group home with a plastic container in which there were a sealed packet of 2 Ho Ho chocolate creme-filled cakes and a 6.75 ounce Hi C box drink.</p> <p>Interview with the QMRP on 6/18/10 at 11:55 a.m., indicated that the resident's behavior support plan (BSP) approved that he be able to purchase a healthy snack from the list provided by the consulting nutritionist. According to the QMRP, Resident #2 purchased regular sodas and the snack cake while he was at his day program.</p> <p>On 6/18/10 at 12:17 p.m., review of Resident #2's BSP dated 10/24/09 revealed, "He should not be</p>	1422		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3818 ALBERMARLE STREET NW WASHINGTON, DC 20008
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I 422 Continued From page 28
allowed to buy anything not on his diet." At the time of the survey, there was no evidence that the resident was being provided continuous active treatment to encourage him to buy those food allowed on his therapeutic diet, in accordance with his approved BSP.

I 422

I 500 3523.1 RESIDENT'S RIGHTS
Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.

This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the three residents in the sample. (Resident #3)

The finding includes:

1. The GHMRP failed to protect residents' rights by not informing the residents' medical guardians of changes in their condition and the use of psychotropic medications for behavior management [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)].

Staff interview and record review revealed the GHMRP failed to secure consent prior to sedating Resident #3 for medical treatment, as evidenced below.

I 500

Cross reference W154

7/29/10

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008
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I 500	<p>Continued From page 29</p> <p>On 6/17/2010 at 2:40 p.m., record review revealed Resident #3 attended a dental assessment, but was not able to complete the assessment due to his maladaptive behavior. Interview with the registered nurse (RN) and the qualified mental retardation professional (QMRP) on 6/17/2010 at 4:10 p.m. revealed Resident #3 was sedated on 4/8/2010 for dental appointment. Further record review on the same day at approximately 4:15 p.m. revealed Resident #3's medication administration record (MAR) confirmed he received 2 mg of Ativan as a measure of sedation for his dental appointment.</p> <p>Interview and additional record review with the GHMRP's qualified mental retardation professional (QMRP) on 6/17/2010 at approximately 4:30 p.m. revealed she received a signed consent for the sedation on 4/9/2010 from the legal guardian, one day after Resident #3 was sedated for his dental appointment.</p> <p>The GHMRP failed to ensure consent was obtained prior to implementing sedation measures to ensure a resident received medical care.</p> <p>II. Cross refer to W154. Based on staff interview and record review, the GHMRP failed to ensure the right of each resident to have unusual incidents investigated thoroughly for one of three residents in the sample (Resident #3)</p> <p>Record review on 6/18/2010 at 11:45 a.m. revealed six (6) unusual incidents were on file at the time of survey in Resident #3's records. Further review revealed there were no investigations on file for any of the six unusual incidents reviewed.</p>	I 500		

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I 500	<p>Continued From page 30</p> <p>II Cross refer to W263. The GHMRP failed to protect residents' rights by not informing the residents' medical guardians of changes in their condition and the use of psychotropic medications for behavior management [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1065(h)].</p> <p>Staff interview and record review revealed the GHMRP failed to secure consent prior to sedating Resident #3 for medical treatment, as evidenced below:</p> <p>On 6/17/2010 at 2:40 p.m., record review revealed Resident #3 attended a dental assessment, but was not able to complete the assessment due to his maladaptive behavior. Interview with the registered nurse (RN) and the qualified mental retardation professional (QMRP) on 6/17/2010 at 4:10 p.m. revealed Resident #3 was sedated on 4/8/2010 for dental appointment. Further record review on the same day at approximately 4:15 p.m. revealed Resident #3's medication administration record (MAR) confirmed he received 2mg of Ativan as a measure of sedation for his dental appointment.</p>	I 500		