

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

PRINTED: 09/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2010
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in which Client #1 was allegedly mistreated by a staff person. Reportedly, the client was told by the staff to stand in a corner of the room with his face to the wall.</p> <p>Due to the nature of the incident and information obtained from the administrative review, Health Regulation and Licensing Administration (HRLA) assigned an on-site investigation on May 27, 2010 to examine the circumstances surrounding Client #1's alleged mistreatment and to verify compliance with the Federal and Local regulatory requirements and standards.</p> <p>The findings of this investigation were based on observations, staff and client interviews and the review of the records to include staff and client interview and the review of the records to include the facility's incident managements system.</p> <p>An on-site investigation was initiated on May 27, 2010 to verify compliance with the Federal and Local regulatory requirements and standards.</p> <p>On June 8, 2010 at approximately 1:00 p.m., interview with the Incident Management Coordinator (IC) it was discovered that Staff #2 filed a false written statement as a part of the facility's internal investigation. It was also discovered that, Staff #2 admitted to the Human Resources Office on May 19, 2010 that she instructed Client #1 to stand in a corner while on duty on May 15, 2010.</p> <p>Based on the investigative report findings, the allegation that Client #1 was mistreated was</p>	W 000		
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
9.20.10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patricia Moore</i>	TITLE <i>Director of Residential Services</i>	(X6) DATE <i>9/17/10</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 000	Continued From page 1 substantiated.	W 000		
W 104	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 interviews and record reviews, the governing body exercised general policy and operating direction over the facility for one the four clients residing in the facility. (Client #1) The findings include: 1. [Cross Reference W153] The facility's governing body failed to ensure that each staff immediately reported observed incidents of mistreatment in accordance with the agency's policy and procedures. 2. [Cross Reference W189] The facility's governing body failed to ensure that each staff's training was effective in accordance with the agency's policy and procedures.	W 104	W104 1. The staff member who failed to report immediately received disciplinary action (written warning) and was re-trained on the incident management policy, with particular attention given to witnessing abuse, neglect or mistreatment...7-1-10 2. As indicated above, the staff member was re-trained on the incident management policy and all staff will be receive training to reinforce their understanding of the policy, particularly as it pertains to reporting abuse/neglect by...9-20-10 The staff member that committed the act (telling Client #1 to stand in a corner) was terminated...7-1-10	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interviews, and record review, the facility failed to implemented the written policies and procedures developed to protect the health and safety of the one client in this investigation.	W 149	W149 All staff will be re-trained on immediate reporting of incidents to insure that they do not compromise the company's ability to report in a timely manner...9-20-10 This training will be reinforced at minimum quarterly...9-30-10	

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W 149	<p>Continued From page 2 (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure the implementation of its "Incident Management" policy as outlined below:</p> <p>[Cross refer to W153] The facility staff failed to generate and report an unusual incident of mistreatment immediately.</p> <p>On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in which Client #1 was allegedly mistreated by a staff person. Reportedly, the client was told by the staff to stand in a corner of the room with his face to the wall.</p>	W 149		
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10)</p> <p>The finding includes:</p>	W 153	<p>W153</p> <p>The staff member who failed to report immediately received disciplinary action (written warning) and was re-trained on the incident management policy, with particular attention given to witnessing abuse, neglect or mistreatment...7-1-10</p>	

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W 153	Continued From page 3 The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on May 27, 2010, at approximately 9:45 AM, revealed the facility failed to report timely the following incident of mistreatment as evidenced below: On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in which Client #1 was allegedly mistreated by a staff person. Reportedly, the client was told by the staff to stand in a corner of the room with his face to the wall. Interview with Staff #1 on May 27, 2010, at approximately 4:00 p.m., revealed that she was not on duty at the time of the alleged incident. Further interview revealed that she was made aware of the incident during a phone conversation with Staff #3. Although, Staff #3 reported to another staff, failed to take personal responsibility for reporting the incident at the time it occurred. Reportedly, Staff #3 requested to remain anonymous and as a result, failed to report this incident to the management as required. Review of the agency's incident management policy and procedure "any staff person witnessing an incident of abuse, neglect and /or mistreatment must immediately report their observation to management". At the time of this investigation, there was no evidence that Staff #3 reported this incident of mistreatment in accordance with the agency's incident policy and procedures.	W 153			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189	W189 All staff members will be re-trained on implementing the BSP of Client #1 and other by...9-27-10 New hires are trained during their initial orientation...9-17-10 The QMRP will observe active treatment implementation weekly to insure routine compliance as will the facility manager separately...9-27-10		

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W 189	<p>Continued From page 4</p> <p>initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for one of six staff in this investigation. (Staff #2)</p> <p>The finding includes:</p> <p>[Cross Reference W149] On June 1, 2010, at approximately 11:30 a.m., an interview with the facility's Qualified Mental Retardation Professional (QMRP) revealed that all staff were taken through a rigorous training during orientation to include a review of the agency's incident management and abuse policy and procedures. Further interview with the QMRP revealed that the agency has a specific policy to address abuse. Reportedly she indicated that the policy as:</p> <p>" No employee, at any time, shall commit an act of physical abuse or emotional abuse or neglect against any client.Employees are duly bound to recognize the rights of all those to whom the facility has entrusted for care and treatment."</p> <p>On June 1, 2010, at approximately 1:30 p.m., review of the agency in-service training log revealed that Staff #2 had been trained on the agency's abuse, neglect and exploitation policies on September 29, 2009, November 14, 2009 and October 17, 2009. Although, Staff #2 was trained</p>	W 189		
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W 189	Continued From page 5 on these policies, The facility failed to ensure that the training was effective as she admitted to mistreatment of Client #1 by instructing him to stand in a corner facing the wall on May 15, 2010. Additionally, Staff #2 failed to address the client target behaviors by implementing his behavior support interventions.	W 189		
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. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for one of the six client's residing in the facility. (Clients #1) The finding includes: The facility staff failed to appropriately implement Client #1's Behavior Support Plan (BSP) Interventions as evidenced below: On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in which Client #1 was allegedly mistreated by a staff person. Reportedly, the client was told by the staff to stand in a corner of the room with his face to the wall.	W 249	W249 All staff members will be re-trained on implementing the BSP of Client #1 and other by...9-27-10 New hires are trained during their initial orientation...9-17-10	

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W 249	<p>Continued From page 6</p> <p>On May 28, 2010 at 4:00 p.m. and interview with the QMRP and the review of Client #1's Behavior Support Plan (BSP) dated January 30, 2010 revealed that he has a target behavior of Stereotyped Rituals Associated with Autistic Disorders. Further review of his target behavior descriptions section included ".....persistent preoccupation with parts of objects or body parts, crying, placing objects in his underwear, tearing paper and stuffing, objects inappropriately placed in clothing". According to the Review of Client #1's BSP revealed a progression of interventions when Stereotype Ritual behavior Associated with Autistic Disorder occurs were as follows:</p> <ol style="list-style-type: none"> 1. Verbal Redirection 2. Gestural Redirection (Nonverbally) 3. Gentle touch with Graduated Guidance technique (Full, Partial or Shadowing) <p>Review of the Human Resources Manager witness statement, Staff #2 indicated that "She did it to prevent him from picking up items and placing them on his body parts". At the time of this investigation, there was no evidence that Staff #2 implemented Client #1's Behavior Support Plan as written.</p>	W 249		

Health Regulation Administration

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1 000	<p>INITIAL COMMENTS</p> <p>On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in which Client #1 was allegedly mistreated by a staff person. Reportedly, the client was told by the staff to stand in a corner of the room with his face to the wall.</p> <p>Due to the nature of the incident and information obtained from the administrative review, Health Regulation and Licensing Administration (HRLA) assigned an on-site investigation on May 27, 2010 to examine the circumstances surrounding Client #1's alleged mistreatment and to verify compliance with the Federal and Local regulatory requirements and standards.</p> <p>The findings of this investigation were based on observations, staff and client interviews and the review of the records to include staff and client interview and the review of the records to include the facility's incident managements system.</p> <p>An on-site investigation was initiated on May 27, 2010 to verify compliance with the Federal and Local regulatory requirements and standards.</p> <p>On June 8, 2010 at approximately 1:00 p.m., interview with the Incident Management Coordinator (IC) it was discovered that Staff #2 filed a false written statement as a part of the facility's internal investigation. It was also discovered that, Staff #2 admitted to the Human Resources Office on May 19, 2010 that she instructed Client #1 to stand in a corner while on duty on May 15, 2010.</p> <p>Based on the investigative report findings, the allegation that Client #1 was mistreated was substantiated.</p>	1 000		
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Health Regulation Administration
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Scott H. House* TITLE: *Director of Residential Services* (X6) DATE: *9/17/10*
 STATE FORM 6888 COT11 If continuation sheet 1 of 4

Health Regulation Administration

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I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for one of the six personnel involved in this investigation. (Staff #2)</p> <p>The finding includes:</p> <p>The GHMRP failed to ensure continuous training for all personnel as evidenced below:</p> <p>On June 1, 2010 at approximately 11:30 a.m., an interview with the facility's Qualified Mental Retardation Professional (QMRP) revealed that all staff were taken through a rigorous training during orientation to include a review of the agency's incident management and abuse policy and procedures. Further interview with the QMRP revealed that the agency has a specific policy to address abuse. Reportedly she indicated that the policy as:</p> <p>" No employee, at any time, shall commit an act of physical abuse or emotional abuse or neglect against any clientEmployees are duly bound to recognize the rights of all those to whom the facility has entrusted for care and treatment."</p> <p>On June 1, 2010 at approximately 1:30 p.m., review of the agency in-service training log revealed that Staff #2 had been trained on the agency's abuse, neglect and exploitation policies on September 29, 2009, November 14, 2009 and October 17, 2009. Although, Staff #2 was trained</p>	I 222	<p>3510.3</p> <p>All staff members will be re-trained on implementing the BSP of Client #1 and other by...9-27-10 New hires are trained during their initial orientation...9-17-10 The QMRP will observe active treatment implementation weekly to insure routine compliance as will the facility manager separately...9-27-10</p>	

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I 222	Continued From page 2 on these policies. The facility failed to ensure that the training was effective as she admitted to mistreatment of Client #1 by instructing him to stand in a corner facing the wall on May 15, 2010. Additionally, Staff #2 failed to address the client target behaviors by implementing his behavior support interventions.	I 222		
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 staff interview and record review, the facility failed to ensure that all incidents were reported immediately to the other officials in accordance with State Law as required by DC Regulation (22 DCMR Chapter 35 Section 3519.10) for one resident in this investigation. (Resident #1) The finding includes: The facility failed to ensure timely reporting of all incidents in accordance with their established policies as evidenced below: On May 18, 2010, the State Surveying Agency (SSA) was notified via facsimile of an incident in	I 379	3519.10 The staff member who failed to report immediately received disciplinary action (written warning) and was re-trained on the incident management policy, with particular attention given to witnessing abuse, neglect or mistreatment...7-1-10 As indicated above, the staff member was re-trained on the incident management policy and all staff will be receive training to reinforce their understanding of the policy, particularly as it pertains to reporting abuse/neglect by...9-20-10	

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I 379	Continued From page 3 which Resident #1 was allegedly mistreated by a staff person. Reportedly, the resident was told by the staff to stand in a corner of the room with his face to the wall.	I 379		

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Health Regulation Administration

Cretter M. Ross
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Residential Services
TITLE

9/17/10 (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2010
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE 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) COMPLETE DATE
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on the interview and review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check or one of the eight personnel files reviewed.</p> <p>The finding includes:</p> <p>On May 28, 2010 at approximately 10:50 a.m. interview with the Qualified Mental Retardation Professional (QMRP) and the review of the personnel records revealed that the GHMRP failed to provide evidence that ensured criminal background checks for one of the six staff files reviewed. [Staff #6]</p>	R 125	<p>R125 4701.5</p> <p>All staff members have criminal background checks including staff member #6 (See: attachments)...9-17-10 Criminal background checks occur prior to the final decision to hire and are a condition of hire in MTS...9-17-10</p>	