

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

PRINTED: 11/24/2010
FORM APPROVED
OMS NO. 0838-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G005	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 11/12/2010
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 FOOTE STREET, NE WASHINGTON, DC 20019
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(K4) 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)	(K5) COMPLETION DATE
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W 800 INITIAL COMMENTS

A recertification survey was conducted on November 9, 2010, November 10, 2010, and November 12, 2010. Due to systemic deficient practices identified during the 2009 recertification survey, the State Agency determined that the full survey process would be utilized. A random sample of two clients was selected from a residential population of two males and two females with various degrees of intellectual and/or developmental disabilities.

The findings of the survey were based on observations in the home and two day programs, interviews with staff in the home and two day programs, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident/investigation reports.

W 120 465.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs, for one of the two clients included in the sample. (Client #2)

The findings include:

- The day program failed to ensure that Client #2 received food in a form consistent with her prescribed dietary needs, as evidenced below.

On November 10, 2010, at 12:10 p.m.,

W 000

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
12.3.10

W 120 Foote Street Survey Responses 2010

W120

The QMRP will meet with the day program of Client number two and share the feedback outlined in W120. The QMRP will insure all day program staff is informed about the correct diet for Client #2 with special attention given to the consideration of insuring that meats are consistently pre-cooked texture... 12-10-10

The QMRP will insure that day program staff understand that Client #2 is capable of drinking from a regular cup and should do so consistently. The QMRP and/or facility manager will monitor lunch meals during monthly program visits to insure that the proper diet is given and that only the adaptive equipment prescribed is consistently used..... 12-10-10

The QMRP will insure that the day program has copies of the current physician's orders and that the program is informed of any changes in Client #2's diet regimen or overall treatment regimen... 12-20-10

AGENCY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE
Patricia Moore, Director of Residential Services TITLE
DATE 12/3/10

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 120	<p>Continued From page 1</p> <p>observations conducted at the day program revealed Client #2's lunch consisted of chicken, string beans, carrots finely chopped. Further observations revealed Client #2 consumed most of her string beans and carrots, but was not observed to eat any of the chicken. Interview with the day program's speech and language staff on the same day at approximately 12:12 p.m. confirmed that all of Client #2's lunch was finely chopped.</p> <p>Review of Client #2's current physician's orders dated September 2010, on November 10, 2010, at approximately 2:30 p.m., revealed the client was prescribed a 1500 calorie, No Added Salt, low fat high fiber Pureed Meats, and finely chopped diet. Review of Client #2's Mealtime Protocol dated January 12, 2010, on the same day at approximately 2:35 p.m., revealed that meats should always be pureed.</p> <p>2. The day program failed to ensure staff used a regular drinking cup for Client #2 while at the day program as recommended.</p> <p>On November 9, 2010, evening observations from 6:09 p.m. to 6:55 p.m. revealed Client #2 was observed to drink her beverage throughout the dinner meal using a regular cup.</p> <p>Observations conducted at the day program on November 10, 2010, at 11:21 a.m., revealed the day program staff was observed to offer Client #2 juice from a two handle mug cup with a white spout lid. At approximately 12:10 p.m., Client #2 was observed drinking grape juice from same cup.</p> <p>Interview with the day program staff on the same day at approximately 12:15 p.m. revealed that</p>	W 120		

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W 120	<p>Continued From page 2</p> <p>Client #2 used the two handle mug cup to assist her with drinking her beverage. A few seconds later, interview with the day program's speech and language staff revealed that she was unsure why Client #2 used the mug cup to assist her with drinking. When asked who provided the mug cup for Client #2, the day program staff stated that the home had sent it (time and date unknown).</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) and registered nurse (RN) on November 10, 2010, at approximately 4:10 p.m., revealed they both were unaware that Client #2 was used a two handle mug cup with the spout lid to assist her with drinking while at the day program. Further interview with the QMRP revealed that the facility did not send the two handle mug cup to Client #2's day program. He stated that Client #2 used a regular to consume her beverage.</p> <p>On November 10, 2010, at approximately 4:35 p.m., review of Client #2's nutritional assessment and mealtime protocol dated January 12, 2010, revealed the client used a hifo scoop plate, plate guard, and adaptive spoon for eating equipment.</p>	W 120		
W 124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by:</p>	W 124		

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W 124	<p>Continued From page 3</p> <p>Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients (Client #2) included in the sample.</p> <p>The finding includes:</p> <p>During the entrance conference on November 9, 2010, at approximately 5:00 p.m., interview with the house manager (HM) revealed that Client #2 had a court appointed legal guardian to assist her with decision making.</p> <p>On November 10, 2010, at approximately 4:15 p.m., review of Client #2's medical book revealed a telephone order dated May 6, 2010, to administer Ativan 4 mg prior to her GYN exam. Interview with the facility's licensed practical nurse (LPN) and review of the medication administration records on November 12, 2010, at approximately 2:30 p.m. revealed that the client received the Ativan 4 mg prior to her GYN exam on May 19, 2010. Further interview with the LPN revealed that she believed that the consent for the use of Ativan had been obtained prior to its use. However, the consent form could not be located.</p> <p>Review of Client #2's Psychological Assessment (dated January 6, 2010) on November 10, 2010, at approximately 4:15 p.m. revealed she "is not able to make independent decisions concerning her residential or day program placement, treatment plan, or financial affairs." At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs,</p>	W 124	<p>W124</p> <p>Formal consent was not obtained prior to the administration of Ativan for Client #2. The Director of Nursing will provide training and feedback to the assigned RN to insure that consent is obtained prior to such a procedure. Additionally, the DON will track and audit such concerns in her monthly meetings with RNs, using a checklist that includes this consideration to audit whether consent has been obtained for upcoming sedation circumstances.....12-15-10</p>		

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W 124	Continued From page 4 including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to her and/or a legally authorized representative.	W 124		
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's direct care staff failed to implement it's incident management policy for one of two clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>1. [Cross Refer W153]. On November 10, 2010, at approximately 1:22 p.m., review of an investigation report dated June 10, 2010 revealed an allegation of neglect. According to the investigation report, on June 1, 2010, it was reported by Client #2's day program staff that she arrived to the day program in a wheel chair that had a broken seatbelt. In addition to the broken seatbelt, the seatbelt was tied in a knot around Client #2 as a method of securing her in the wheel chair. Further review of the investigation report revealed that the allegation of neglect was substantiated.</p> <p>Interview was conducted with the facility's qualified mental retardation professional (QMRP) on November 12, 2010, at approximately 3:06 p.m., to ascertain if the facility had a written incident management policy. The QMRP</p>	W 149		

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W 149	<p>Continued From page 5</p> <p>provided a policy entitled "Interagency Policy Review". Review of policy included the following requirements pertaining to abuse, neglect or mistreatment reporting:</p> <ul style="list-style-type: none"> - report the incident to a supervisor immediately; - report to the administrator; - follow the instructions given by the supervisor, and - complete an incident report. - report to the Department of Health <p>At the time of the survey, there was no evidence that the facility implemented its incident management policy, as required.</p> <p>2. [Cross refer to W154 and W192] The facility failed to implement its policy on staff training, prior to implementation of adaptive equipment for Client #1, as evidenced below.</p> <p>On November 12, 2010, at 2:35 p.m., interview was conducted with the licensed practical nurse (LPN) and with the direct support personnel (DSP) who escorted the client to pick up his bilateral hand splints from the provider on August 25, 2010. During the interview they stated that the attending DSP conducted training on how to use of the splints on the same day the client received them. Interview with the LPN revealed that the policy required that the professional recommending an assistive device be contacted to train staff before using the device.</p> <p>On November 12, 2010 at 2:30 p.m., review of a</p>	W 149	<p>W149</p> <ol style="list-style-type: none"> 1. The Director of Residential Programs will conduct a training session, assisted by the Staff IMC, on the DDS and MTS incident management policies with the QMRP and Facility Manager to insure that both monitor the necessary follow up steps for all incidents that occur for the cluster they support...12-10-10 <p>The Corporate IMC and Staff IMC will monitor all follow up steps in an incident-specific manner to insure that 100% of the required steps are completed...12-10-10</p> <ol style="list-style-type: none"> 2. All staff will be re-trained by the assigned RN to insure that they understand the use of any adaptive equipment must be specifically authorized by qualified personnel. The RN and QMRP will monitor the implementation of any new adaptive equipment to insure that it is used only after proper training has been implemented by the appropriate clinical professional.... 12-10-10 	

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W 149	Continued From page 6 training agenda dated September 24, 2010, revealed the program director addressed procedures for implementing new adaptive equipment. The training details revealed Client #1 should not have worn the hand splints until after staff were trained by the professional who recommended them. At the time of the survey, there was no evidence that the facility timely implemented this policy to prevent injury of the client's hand caused by his wearing bilateral hand splints.	W 149		
153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153		
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of neglect were immediately reported to the administrator and to other officials in accordance with State Law, for one of the two clients (Client #2) included in the sample.		The proper notifications did occur but the QMRP failed to document the notifications in the proper areas of the incident report form. The IMC will provide additional training to the QMRP and facility manager to insure that all notifications are indicated for each incident that occurs and that all appropriate information is completed... 12-10-10. Additionally, the IMC will review each incident report form before it is submitted to insure that it has 100% of the required information... 12-2-10.	
	The finding includes: On November 10, 2010, at approximately 1:22 p.m., review of an investigation report dated June 10, 2010 revealed an allegation of neglect. According to the investigation report, on June 1, 2010, it was reported by Client #2's day program staff that she arrived to the day program in a wheel chair that had a broken seatbelt. In			

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W 153	<p>Continued From page 7</p> <p>addition to the broken seatbelt, the seatbelt was tied in a knot around Client #2 as a method of securing her in the wheel chair. Further review of the investigation report revealed that the allegation of neglect was substantiated.</p> <p>Interview was conducted with the facility's qualified mental retardation professional (QMRP) on November 10, 2010, at approximately 2:30 p.m. to ascertain information about the incident and find out the facility's policy on required notifications. Interview revealed that the Department of Health and the administrator were to be notified. However, at the time of the survey, the facility failed to provide evidence that the aforementioned incident was reported to both the facility's administrator and the Department of Health as required.</p>	W 153		
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on Interview and record review, the facility failed to ensure the an unusual incident involving an injury was investigated thoroughly and timely for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>During the entrance conference on November 9, 2010 at approximately 5:00 p.m., the qualified mental retardation professional (QMRP) was requested to provide a copy of all unusual incident reports and the corresponding investigation reports to the surveyor for review.</p>	W 154	<p>The QMRP will be charged with developing an investigation report that reflects the findings and recommendations for this incident and that report will be submitted by... 12-15-10</p> <p>The Corporate IMC tracks this requirement and will provide feedback to the assigned investigator and the Director of Residential Services routinely to insure that timelines are met on a consistent basis... 12-15-10</p> <p>Additionally, the Director of Residential Services will audit this concern with each QMRP during monthly meetings... 12-15-10</p>	

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W 154	<p>Continued From page 8</p> <p>The review of unusual incident reports (UIRs) on November 10, 2010, at 5:41 p.m. revealed that on September 17, 2010, at 9:00 p.m., a direct support staff (DSP) observed Client #1's facial grimacing when his hand splints were removed. The UIR revealed that upon closer observation, the DSP saw "a deep cut between his [Client #1's] thumb." The DSP informed the other two staff on duty, then called the Director of Nursing (DON). The DON requested the DSP to telephone the house manager, the overnight shift, and the primary registered nurse (PRN) of the client's hand injury. The nurse further instructed staff to discontinue applying the client's hand splints.</p> <p>Record review on November 10, 2010, at 7:30 p.m., however, revealed no corresponding report was available detailing the outcome of the investigation of Client #1's hand injury. Interview with the QMRP on November 12, 2010 at 2:40 p.m., acknowledged that the investigation report was not available.</p>	W 154		
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an investigation of neglect was reviewed by the administrator within five working days, for two of two clients included in the sample. (Clients #1 and #2)</p>	W 156	<p>1/2: Incident investigations will be reviewed and approved in the future as evidenced by the signature of the Director of Residential Services on the last page of the document with the review/approval date indicated... 12-10-10</p>	

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W 156 Continued From page 9
The findings include:

1. [Cross refer to W153]. On November 10, 2010, at approximately 1:22 p.m., review of an investigation report dated June 10, 2010 revealed an allegation of neglect. According to the investigation report, on June 1, 2010, it was reported by Client #2's day program staff that she arrived to the day program in a wheel chair that had a broken seatbelt. In addition to the broken seatbelt, the seatbelt was tied in a knot around Client #2 as a method of securing her in the wheel chair. Further review of the investigation report revealed that the Incident Management Coordinator substantiated the allegation of neglect.

Review of the facility's Incident Management Policy (IMP) on November 12, 2010, at approximately 3:08 p.m. revealed "The results of all investigations will be reported to the administrator within five working days". There was no written evidence that the results of the investigation was reviewed by the administrator.

2. [Cross refer to W154] The facility failed to ensure that the outcome of an investigation of Client #1's hand injury was reported to the administrator within five working days, as evidences below.

The review of unusual incidents reports on November 10, 2010, at 5:41 p.m., revealed that on September 17, 2010, at 9:00 p.m. a direct support staff discovered skin breakdown on Client #1's hands, which appeared to be related to his wearing bilateral hand splints.

Interview with the qualified mental retardation

W 156

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W 158	Continued From page 10 professional (QMRP) on November 12, 2010 at 2:40 p.m., revealed that the results of the investigation of the incident were not available. There was no documented evidence that the outcome of an investigation of the incident was reviewed by the administrator.	W 158		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for two of two clients included in the sample. (Clients #1 and #2) The findings include: 1. [Cross Refer to W154]. The QMRP failed to ensure coordination of services for the appropriate use of Client #1's bilateral hand splints, as evidenced below. Interview with the primary registered nurse on November 10, 2010 at 5:16 p.m. revealed on September 17, 2010 she was notified that Client #1 had a cut between his finger and thumb. On November 10, 2010, at 5:16 p.m. record review revealed a physician's order dated September 19, 2010, to "Hold splint usage until reevaluation by therapist."	W 159	1/2 All staff will be re-trained by the assigned RN to insure that they understand the use of any adaptive equipment must be specifically authorized by qualified personnel. The RN and QMRP will monitor the implementation of any new adaptive equipment to insure that it is used only after proper training has been implemented by the appropriate clinical professional.....12-10-10 3 The RN will follow up to insure that Client #2 has the needed bed alarm...12-15-10 The QMRP and RN separately will review the medical records monthly to audit for and follow up on such considerations...12-20-10 The QMRP, RN and Facility Manager meet monthly as a team to discuss person-specific medical/treatment concerns and will discuss follow up on such considerations during these monthly team meetings...12-20-10 4 The QMRP will add an oral hygiene objective for Client #2 and train staff on its implementation. Implementation of the new objective will begin...1-2-11 5 As indicated earlier in the survey response, the QMRP will meet with the day program staff for Client #2 to insure that meals and snacks are implemented properly in accordance with the prescribed diet and adaptive equipment supports...12-15-10	

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019
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W 159	<p>Continued From page 11</p> <p>Further record review on November 10, 2010 revealed the following information concerning Client #1's hand splints:</p> <p>(a) July 1, 2010 - Evaluation for wrist splints. Recommendation: may benefit from more customized fit due to severity of deformity. Patient measured for splints. Will call to schedule follow-up appointment.</p> <p>(b) August 25, 2010 - Received the hand splints. On November 12, 2010, at 2:35 p.m. interview with the licensed practical nurse (LPN) and with the DSP who escorted the client to pick up the splints from the provider, revealed that DSP had conducted the training for the staff. Interview with the QMRP and the record review on November 12, 2010 at approximately 3:15 p.m. revealed the physical therapist was not notified when the client received the hand splints, and therefore did not provide training to staff on their use.</p> <p>2. [Cross refer to w192] The QMRP failed to coordinate services with the group home and day program staff to ensure they were trained to manage the Client #1's bilateral hand splints.</p> <p>3. The facility's QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure the Occupational Therapist's recommendation was addressed for Client #2 in a timely manner.</p> <p>Review of Client #2's occupational therapy (OT) consult dated May 14, 2010, on November 10, 2010, at approximately 5:30 p.m., revealed a recommendation for an Infrared bed alarm.</p>	W 159		

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W 159	<p>Continued From page 12</p> <p>During a face to face interview with the QMRP and the Registered Nurse Supervisor on June 25, 2010, at approximately 5:30 p.m., it was acknowledged that the IDT had not addressed the infrared bed alarm for Client #2.</p> <p>Review of Client #2's medical assessment dated January 7, 2010, on November 10, 2010, at approximately 3:50 p.m., revealed the client was at risk for falls and has diagnoses that included osteoporosis of the lumbar spine, degenerative disease bilateral knees, right foot drop, exotropia cataracts and ocular hypertension.</p> <p>There was no documented evidence the IDT addressed the occupational therapist's recommendation for the client to have an infrared bed alarm.</p> <p>4. Cross Refer to W242. The facility's QMRP failed to coordinate services to ensure Client #2's individual program plan (IPP) included training to improve dental hygiene.</p> <p>5. Cross Refer to W120. The QMRP failed to coordinate and monitor services to ensure Client #2's day program used the correct feeding equipment during meals.</p>	W 159		
N 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that each staff was effectively trained to address the health care needs of one of</p>	W 192		

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W 192	<p>Continued From page 13 two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that staff training was timely and effective to minimize Client #1's risk of injury due to wearing bilateral hand splints, as evidenced below:</p> <p>The review of unusual incidents on November 10, 2010, at 5:01 p.m. revealed that on September 17, 2010, at 9:00 p.m., a direct support staff (DSP) observed skin breakdown on Client #1's hands when removing his hand splints.</p> <p>On November 10, 2010, at 6:57 p.m., interview with the primary registered nurse (PRN) revealed she was informed that staff had been trained on how to use the hand splints prior to their use. Further discussion with the PRN, revealed, however, that she was unable to verify who had conducted the training for the staff. On November 12, 2010, at 2:35 p.m. interview was conducted with the licensed practical nurse (LPN) and with the DSP who escorted the client to pick up the splints from the provider. This discussion revealed the DSP provided training for the staff when the client received the splints on August 25, 2010.</p> <p>On November 12, 2010 at 1:30 p.m., review of Client #1's PT assessment dated June 28, 2010 revealed the physical therapist (PT) recommended to "Consider an evaluation by an outpatient occupational therapist and to fabricate a resting wrist/hand splint for each extremity." Further interview with the LPN, revealed that the physical therapist (PT) who recommended the hand splints for the client should have been</p>	W 192	<p>W192</p> <p>The PT trained staff on the use of the custom molded hand splints on... 12-3-10</p>	
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W 192	<p>Continued From page 14</p> <p>notified to provide staff training on the splints prior to their use by the client.</p> <p>On November 12, 2010 at 2:30 p.m., a training agenda dated September 24, 2010 documented the program director instructions to the qualified mental retardation professional (QMRP) the LPN, and the house manager regarding Client #1's wearing of the hand splints. According to the agenda, the splints should not have been worn by the client until after staff training was provided by the professional who recommended them. Training on the use of the client's hand splints was suspended, pending his evaluation and receipt of custom molded hand splints.</p> <p>At the time of the survey, however, there was no evidence that all staff responsible for applying, removing, and monitoring Client #1 hand splints had received training from a qualified professional prior to/during their use.</p>	W 192		
W 242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for one of the two clients in the</p>	W 242		

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W 242	<p>Continued From page 15 sample. (Client #2)</p> <p>The finding includes:</p> <p>Review of Client #2's dental consultation dated June 15, 2010, on November 10, 2010 at approximately revealed tooth #7 was extracted and peri-evaluation/peri-orbital exam revealed advanced bone loss and gingival recession around tooth #15. Further review of Client #2's dental consult dated October 18, 2010, on November 10, 2010 revealed a recommendation that the client brush her teeth two (2) times a day.</p> <p>Review of Client #2's Individual Program Plan (IPP) dated November 2010, on November 10, 2010 at approximately 4:45 p.m., revealed no evidence of a training program to address the client's oral hygiene.</p> <p>On November 10, 2010 at approximately 5:30 p.m., the qualified mental retardation professional (QMRP) acknowledged during a face to face interview that Client #2 did not have a training program to address her dental hygiene.</p> <p>There was no evidence the facility ensured the client's IPP included training in activities of dental hygiene.</p>	W 242	<p>W242</p> <p>The QMRP will add an oral hygiene objective for Client #2 and train staff on its implementation. Implementation of the new objective will begin... 1-2-11</p>	
N 262	<p>483.440(1)(3)(I) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p>	W 262		

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W 262	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of two two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>[Cross refer to W154] The facility failed to provide evidence that its HRC monitored and approved the use of hand splints worn by Client #1, and evidenced below:</p> <p>On November 12, 2010, at 2:33 p.m. the licensed practical nurse (LPN) showed the survey bilateral hand splints, which she stated belonged to Client #1 and confirmed that they were worn by the client.</p> <p>Further discussion with the LPN on November 12, 2010, at 2:47 p.m. revealed that the use of the bilateral hand splints was initiated on August 25, 2010. The LPN indicated that the splints were discontinued on September 17, 2010, after staff reported skin breakdown on the client's hands. The LPN acknowledged that she was not aware that the new hand splints required approval by the HRC prior to their use by the client.</p> <p>On November 12, 2010, at 2:52 p.m. the review of the HRC meeting minutes for the current survey period, revealed no evidence the bilateral hand splints worn by Client #1 from August 25, 2010 to September 17, 2010 had been approved.</p>	W 262	<p>W262</p> <p>Client #1's hand splints issue will be brought before the internal HRC for review and approval in the next meeting held... 12-28-10. The committee's feedback and recommendations will be documented... 12-28-10 The QMRP will insure in the future that any planned measures that are restrictive in nature are brought before the HRC for review and approval... 1-2-11</p>	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263		

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W 263	<p>Continued From page 17</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: Based on interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of two clients include in the sample. (Client #2)</p> <p>The finding includes:</p> <p>[Cross refer to W124.] The facility failed to ensure that written informed consent was obtained prior to the administration of sedation for Client #2.</p>	W 263	<p>W263</p> <p>Formal consent was not obtained prior to the administration of Ativan for Client #2. The Director of Nursing will provide training and feedback to the assigned RN to insure that consent is obtained prior to such a procedure. Additionally, the DON will track and audit such concerns in her monthly meetings with RNs, using a checklist that includes this consideration to audit whether consent has been obtained for upcoming sedation circumstances.....12-15-10</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely preventive and general care, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>1. [Cross refer to W154 and W331]. Interview with the licensed practical nurse (LPN) on November 12, 2010 at 2:20 p.m. indicated the</p>	W 322		

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W 322	<p>Continued From page 18</p> <p>primary care physician (PCP) monitored Client #1's hand injuries caused by wearing bilateral hand splints received and worn, beginning on August 25, 2010. Continued interview with the qualified mental retardation professional (QMRP) and the LPN revealed a physician's order prescribing the bilateral hand splints and a 719A authorizing their use by the client, were not available.</p> <p>On November 12, 2010, at 1:30 p.m. the record revealed on June 28, 2010 the physical therapist (PT) recommended to "Consider an evaluation by an outpatient occupational therapist and to fabricate a resting wrist/hand splint for each extremity," for Client #1. On July 1, 2010 the orthotic clinic documented, "May benefit from more customized fit due to severity of deformity." The next PT follow-up assessment dated October 19, 2010, revealed the client had skin breakdown on his left thumb and right web space, which was reported to have been caused by the hand splints. The PT observed that the right hand strap pressed into the webspace, the left thumb pressed into the hand roll, and trace movement of both hands and digits was permitted by the splints. PT acknowledged that the hand splints had been discontinued, however, recommended that the client return to the vendor for appropriate hand splints to accommodate his bilateral wrist flexion contractures.</p> <p>Review of Client #1's medical record on November 12, 2010 at 1:37 p.m. revealed that the PCP monitored the hand splints, beginning on September 9, 2010, as evidenced below:</p> <p>(a) September 9, 2010- Monthly checkup. "Re-evaluate the splint". There was no</p>	W 322	<p>W322</p> <p>PT is visiting Client #1 on 12-3-10 to reassess the splint situation. In the meantime, the vendor has sent a new set of splints that they feel address the issues caused by the initial set of splints (ill-fitting causing a cut). These splints are not being used. PT will assess whether the new splints are appropriate and safe to use. If they are, PT will train staff immediately on the use of the splints...12-3-10. If the newly proposed set of splints is deemed inappropriate, they will be returned to the vendor and PT will provide specific instructions for the vendor as to the model of splints that will be appropriate for Client #1.....12-3-10. PT will document the findings and decisions made and will document staff training if staff training and implementation of the use of the new splints are deemed appropriate.....12-3-10</p>		

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W 322	<p>Continued From page 19</p> <p>mentioning of the client's tolerance of the hand splints.</p> <p>(b) September 21, 2010 - Open area between thumb and first finger of right hand; topical antibiotic. Bactroban, Keflex TID. Clean with peroxide. Keep area open.</p> <p>(c) October 7, 2010 consult. - Open area on 9/20/2010; Discharge site now clear. Still open, no drainage. May return to day program.</p> <p>At the time of the survey exit, however, the physician's order and the 719A for the bilateral hand splints remained unavailable. There was no evidence that the September 9, 2010 medical assessment by the PCP documented an evaluation of the hand skin integrity. There was also no evidence the facility ensured that the client was provided a timely reassessment of the bilateral hand splints, as recommended by the PCP.</p>	W 322		
W 331	<p>483.460(c) NURSING SERVICES</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 observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for two of four clients residing in the facility; (Clients #2 and # 4)</p> <p>The findings include:</p> <p>1. [Cross refer to W368 and W369] The facility's</p>	W 331		

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W 331	<p>Continued From page 20</p> <p>nursing staff failed to ensure that all drugs were administered in compliance with the physician's orders.</p> <p>2. [Cross refer to W322] The facility's nursing services failed to coordinate services closely with the primary care physician to ensure timely preventive services for Client #2.</p> <p>3. [Cross refer to W356] The facility's nursing services failed to ensure timely dental follow-up services for Client #2.</p> <p>4. [Cross refer to W154] The facility's nursing services failed to ensure Client #1's tolerance of hand splints was closely monitored, as evidenced below:</p> <p>On November 10, 2010, at 6:57 p.m., interview with the primary registered nurse (PRN) revealed she was informed that staff had been trained on how to use the hand splints prior to their use, however she was unable to verify who had conducted the training for the staff. On November 12, 2010, at 2:35 p.m. interview with the licensed practical nurse (LPN) and with the DSP who escorted the client to pick up the splints from the provider, revealed that DSP had conducted the training for the staff. According to the LPN, however, she was not aware that the client had received the hand splints until September 7, 2010, when she observed the client wearing them. Further interview with the LPN, however indicated that the physical therapist who recommended the hand splints for the client should have been notified to provide training to staff on the splints prior to their use by the client.</p> <p>Record review on November 12, 2010, at 1:40</p>	W 331	<p>W331</p> <p>In addition to the following responses, see also the responses for W368, W369, W322, W356 and W154.</p> <p>The RN will add the hand and splint issues to the HMCP outlining the treatment and follow up steps and the monitoring parameters...12-10-10.</p> <p>The QMRP will review the medical records monthly to insure that such updates (in the nursing notes and on the HMCP) occur and the QMRP, RN and facility manager will meet monthly to discuss all health care issues for each person supported. One of the central questions routinely addressed will be whether there are any new issues or developments that require changes in the HMCP.....12-15-10</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2010
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 21</p> <p>p.m. revealed that there was no documentation to show nursing monitoring of Client #1's bilateral hand splints until September 18, 2010. A September 18, 2010 (7:30 a.m.) progress note revealed DSP reported drainage from the webspace between the thumb and fourth finger on both hands due to splint application. Upon assessment, the nurse noted a purulent wound on the right (thumb)web space, about one inch long and 1/2inch deep with whitish drainage. The nurse also documented a healing wound without drainage on left thumb. The progress note further documented that the primary care physician (PCP)and the primary registered nurse (RN) were notified. The PCP prescribed Keflex 500 mg twice daily for seven days and Bacitracin to both hands until healed. The PCP also order that the splint usage be discontinued until reevaluation by the therapist.</p> <p>At the time of the survey, however, there was no evidence that nursing services had timely implemented a system to monitor Client #1's tolerance of his bilateral hand splints to ensure a proper fit, and to prevent the risk of skin breakdown.</p>	W 331		
W 336	<p>483.460(e)(3)(II) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's registered nurse (RN) failed to ensure physical examinations were conducted quarterly</p>	W 336	<p>W336</p> <p>The DON will re-train the RN on completing quarterly nursing physicals and will insure that the RN using the prescribed MTS tracking format to proactively track deadlines for each required quarterly...12-10-10 The QMRP will audit compliance during the routine monthly medical records review and will inform both the DON and assigned RN when issues are uncovered..... 12-10-10</p>	

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W 336	Continued From page 22 or on a more frequent basis, for one of two clients included in the sample. (Client #2) The finding includes: Interview with the facility's Registered Nurse (RN) Supervisor on November 10, 2010, at approximately 8:00 p.m., revealed that the RN should complete quarterly nursing exams. Review of Client #2's medical record on November 10, 2010, beginning at 3:35 p.m., revealed an annual nursing assessment date January 12, 2010. Further review revealed no quarterly nursing reviews for April and July 2010. The RN Supervisor confirmed the missing April and July nursing quarterly reviews for Client #2.	W 336		
W 356	483.480(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 for one of three clients in the sample. (Client #2) The finding includes: The facility's failed to ensure timely dental follow-up services for Client #2 as evidenced by: Review of Client #2's dental consultation dated June 15, 2010, on November 10, 2010 at	W 356	W356 The RN will reschedule the dental visit for Client #2... 12-10-10 The failure of the system to approve prior authorizations in a timely manner causes delays in dental treatment and the cancellation of scheduled follow up. DDS has informed the provider community that this issue has been resolved..... 12-2-10	

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W 355	Continued From page 23 approximately revealed tooth #7 was extracted and peri-evaluation/peri-orbital exam revealed advanced bone loss and gingival recession around tooth #15. Further review of Client #2's of the dental consult recommended the client return on July 18, 2010 for extraction of tooth #15. During a face to face interview with the Registered Nurse (RN) Supervisor Professional on November 10, 2010 at approximately 6:58 p.m., it was acknowledged Client #2 did not return on July 18, 2010 for extraction of tooth #15.	W 355		
W 368	483.450(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on staff observation, interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders for two of four clients residing in the facility. (Client # 1 and #4) The findings include: 1. Observation of the evening medication administration on November 10, 2010, at approximately 7:01 p.m., revealed Licensed Practical Nurse #1 (LPN #1) administered Client #1, Phenobarbital 60 mg. one tablet by mouth. Review of Client # 1's physician's order sheet (POS) dated November, 2010, on November 10, 2010, at approximately 7:05 p.m., revealed an order to administer Phenobarbital 60 mg. one tablet by mouth.	W 368	W368 The RN and PCP have met to discuss the prescribed regimen for both Client #1's Phenobarbital and Client #4's eye drops. These regimens will be modified and the modified schedules will be routinely followed by the medication nurses... 12-10-10 The RN will review the regimens with the LPNs to insure proper implementation routinely and will monitor implementation on a routine weekly basis... 12-10-10	

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W 368 Continued From page 24 at bedtime.

During a face to face interview with LPN #1 and Registered Nurse (RN) Supervisor on November 10, 2010, at approximately 7:20 p.m., it was acknowledged Phenobarbital 60 mg. one tablet by mouth was administered at 7:01 p.m., in the evening and was not administered at bedtime.

2. Observation of the evening medication administration on November 10, 2010, at approximately 7:20 p.m., revealed LPN #1 administered Client #4, Travatan ophthalmic 0.001% drops in both eyes.

Review of Client # 4's POS dated September 2010, on November 10, 2010, at approximately 7:21 p.m., revealed an order to administer Travatan ophthalmic 0.001% three (3) drops in both eyes at bedtime for ocular pressure.

During a face-to-face interview with LPN #1 and the RN Supervisor on November 10, 2010, at approximately 7:22 p.m., it was acknowledged Client #4 was not administered Travatan ophthalmic 0.001% three (3) drops in both eyes at bedtime.

W 368

W 369 483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for two of four clients in the

W 369

The RN and PCP have met to discuss the prescribed regimen for both Client #1's Phenobarbital and Client #4's eye drops. These regimens will be modified and the modified schedules will be routinely followed by the medication nurses... 12-10-10
The RN will review the regimens with the LPNs to insure proper implementation routinely and will monitor implementation on a routine weekly basis... 12-10-10

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W 369	Continued From page 25 facility. (Client # 1 and Client #4) The finding includes: [Cross refer to W368.] The facility failed to ensure that medications prescribed for Clients #1 and #4 were administered at the prescribed time.	W 369		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts for four of four clients residing in the facility. (Clients #1, #2, #3, and #4) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On November 12, 2010, at 11:17 a.m., interview with the house manager (HM) revealed that there were three designated shifts (7:00 AM -3:00 PM; 3:00 PM -11:00 PM and 11:00 PM - 7:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM) for the weekend (Saturday/Sunday). Review of the facility's fire drill log records on the same day at approximately 11:20 a.m., revealed that no drills were held during the weekday evening shift from January 2010 through March 2010. In addition, there were no fire drills held	W 440	W440 A modified fire drill schedule will be developed by the QMRP for the remainder of December that will address the deficiencies cited but will insure that no more than 1 make up drill per week is scheduled/implemented... 12-30-10 MTS will develop and train all managers of a standard schedule for 2011 that if properly implemented, insures that each shift experiences a fire drill at minimum once quarterly... 1-2-11	

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W 440	Continued From page 26 during the weekend morning/evening shifts from January 2010 through May 2010. This was acknowledged by the facility's qualified mental retardation professional (QMRF) on November 12, 2010, at 11:48 p.m.	W 440		
W 455	<p>483.470(i)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of four clients residing in the residence. (Client #3)</p> <p>The finding includes:</p> <p>On November 10, 2010, at approximately 6:14 p.m., Licensed Practical Nurse #1 (LPN #1) was observed to wash both hands with soap and water prior to administering medications. However, LPN #1 touched the blister pack, Medication Administration Records (MAR's), medication cabinet and the rim of Client #3's medication cup when punching out an Amantadine 100 mg tablet from the blister pack without sanitizing her hands.</p> <p>During a face to face interview with LPN #1 on November 10, 2010, at approximately 6:15 p.m., it was acknowledged after washing her hands, she touched the blister pack, MAR's, medication cabinet and the rim of Client #3's medication cup when punching out an Amantadine 100 mg tablet from the blister pack without sanitizing her hands.</p>	W 455	<p>W455</p> <p>The assigned RN will re-train the medication nurse on proper infection control practices and document the training... 12-15-10</p> <p>The assigned RN, QMRF and/or facility manager will monitor medication passing on a routine weekly basis to insure compliance... 12-30-10</p>	

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W 455	Continued From page 27	W 455		
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 observations, interviews and record review, the facility failed to serve each food in a form consistent with the prescribed texture, for one of the two clients included in the sample. (Client #2) The findings include: 1. The facility failed to ensure that Client #2 received food in a form consistent with her prescribed dietary needs, as evidenced below: On November 10, 2010, at 4:21 p.m., observations of the evening snack revealed Client #2 was served cantaloupe bite size in a high low scoop plate. Before the client could eat any of the cantaloupe, the surveyor asked Staff #1, the qualified mental retardation professional (QMRP), and the registered nurse (RN) to verify that Client #2's cantaloupe was served bite size. The QMRP, RN, and Staff #3 acknowledged that the client's fruit was not of the right texture as prescribed. Interview with the RN revealed that Client #2 was at risk for aspiration. Review of Client #2's current physician's orders dated September 2010, on November 10, 2010, at approximately 2:30 p.m., revealed the client	W 474	W474 1 All shifts were trained on the meal protocols by.....12-2-10. The QMRP and facility manager separately will monitor meal implementation at minimum weekly for all shifts to insure that the diet regimens of each person are routinely followed as prescribed... 12-30-10 2 The QMRP will meet with the day program of Client number two and share the feedback outlined in W120. The QMRP will insure all day program staff is informed about the correct diet for Client #2 with special attention given to the consideration of insuring that meats are consistently purced texture... 12-10-10 The QMRP will insure that day program staff understand that Client #2 is capable of drinking from a regular cup and should do so consistently. The QMRP and/or facility manager will monitor lunch meals during monthly program visits to insure that the proper diet is given and that only the adaptive equipment prescribed is consistently used... 12-10-10 The QMRP will insure that the day program has copies of the current physician's orders and that the program is informed of any changes in Client #2's diet regimen or overall treatment regimen... 12-20-10	

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W 474	<p>Continued From page 28</p> <p>was prescribed a 1500 calorie, No Added Salt, low fat high fiber Pureed Meats, and finely chopped diet. Review of Client #2 's Mealtime Protocol dated January 12, 2010, on the same day at approximately 2:35 p.m., revealed that meats should always be pureed.</p> <p>Note: It should be noted that the QMRP was observed to provide immediately training to all staff on the evening shift on the clients ' mealtime protocols. The QMRP stated that the other shifts would be trained on the protocols on November 11, 2010.</p> <p>2. Cross refer to W120. The day program failed to ensure that Client #2 received food in a form consistent with her prescribed dietary needs.</p>	W 474		
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Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019	

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R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted on November 9, 2010, November 10, 2010, and November 12, 2010. A random sampling of two clients was selected from a residential population of two males and two females with various degrees of intellectual and/or developmental disabilities.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with staff in the home and the day programs, as well as a review of the clinical, administrative, and rehabilitative records, including a review of the unusual incident/investigation reports.</p>	R 000		
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 review of personnel records and interview, the agency failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for one of the fifteen (15) staff employed. (Staff #15)</p> <p>The findings include:</p> <p>On November 12, 2010, beginning at approximately 11:30 a.m., review of the personnel records revealed Direct Care Staff #15, had no documented evidence of a</p>	R 125	<p>R125 4701.5</p> <p>Attached is the background check for Staff Member #15...12-2-10</p>	

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

TITLE

(X6) DATE

FORM

6025-11

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R 125	<p>Continued From page 1</p> <p>comprehensive criminal background check on file for review. The qualified mental retardation professional (QMRP) acknowledged that the record was not available.</p> <p>At the time of the survey, there was no evidence the GHMRP ensured each staff had criminal background check.</p>	R 125		