

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

PRINTED: 08/17/2011  
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  07/28/2011
--	--	--	--

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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000 INITIAL COMMENTS

W 000

On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of three (3) allegations of physical and verbal abuse from the Office of the Inspector General, via e-mail. The email identified the following concerns:

Allegation #1: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that while Client #1 used the bathroom during shift change, Staff #2 yelled (pee, pee) and hit him until he used the bathroom. Conclusion: The allegation could not be substantiated.

Allegation #2: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter regarding a physical injury to Client #1's right eye. According the confidential reporter, allegedly on May 6, 2011, Client #2 sustained a scratch underneath his eye and had a swollen face when Staff #3 hit the client for having a behavior. Conclusion: The allegation could not be substantiated.

Allegation #2: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that Staff #1 yelled at Client #2 using profanity and put his hands on him several times. Conclusion: The allegation could not be substantiated.

Due to the nature of the alleged allegations, on July 27, 2011, an onsite investigation was initiated in conjunction with a recertification survey conducted from July 27, 2011 through July 28, 2011. A sample of two clients was selected from

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Getta H. Mason</i>	TITLE <i>Director of Residential Services</i>	(X6) DATE <i>8/26/11</i>
--	--	-----------------------------

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.

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000 Continued From page 1  
a population of four men with varying degrees of intellectual disabilities.

The findings of the investigation and survey were based on observations and interviews with the staff and clients in the home and at one day program, interview with two guardians, as well as a review of the clinical and administrative records including incident/investigation reports.

The results of the investigative and survey findings revealed that the state agency determined that the facility meet the Condition of Participation requirements in Governing Body, Client Protection and Facility Staffing by removing all alleged staff from client contact pending the outcome of the investigation. The investigation, however, did substantiate the following:

- a) The facility failed to implement their incident management policy on reporting and investigating allegations of abuse;
- b) The facility the failed to report the alleged allegations to the DOH timely and;
- c) The facility failed to ensure that the results of all investigations were reported to the administrator within five working days.

W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS

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.

W 000

W 124

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 124 Continued From page 2

This STANDARD is not met as evidenced by:  
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 two clients included in the sample. (Client #2)

The finding includes:

During the entrance conference on July 27, 2011, at 9:13 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that Client #2 had a mother that operated as the client's designated surrogate healthcare decision-maker (guardian) due to the client's inability to give informed consent for the use of his medications.

On July 28, 2011, at 11:33 a.m., review of Client #2's medical book revealed a written physician's order (PO) dated June 22, 2011, that documented that Client #2 was recently prescribed Chlorpromazine 200 mg one tab in the morning for increased maladaptive behaviors.

On July 28, 2011, at approximately 1:30 p.m., interview with the registered nurse (RN) confirmed that Chlorpromazine 200 mg was prescribed for the morning due to Client #2's increased behaviors on June 22, 2011. When asked if the client's guardian had been informed of the medication increase, the RN replied by saying "yes". However, the RN did state that she

W 124

August 25, 2011

W124

The mother of Client #2 was informed about the medication change/increase and the reasons for the proposed increase. She did agree with the medication change after receiving risks/benefits information and an MTS staff member went to her home to obtain her signature on a formal consent form. This form was not immediately given to the QIDP for proper filing but has been located and filed (See: Attached copy)...8-24-11 In the future, the QIDP will insure that signed consents are immediately filed in the client record and will audit the records on a routine monthly basis to insure integrity is maintained...8-30-11

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 124 Continued From page 3  
had not obtained a written consent from the client's guardian. Interview with Client #2's guardian on July 28, 2011, at approximately 3:25 p.m., revealed that she had not signed any consents for the addition of Chlorpromazine 200 mg prescribed for the morning time. On July 28, 2011, at 11:55 a.m. review of Client #2's Psychological Assessment, dated July 10, 2010, revealed a section entitled "Competency Statement." According to that section, he is not able to make independent decisions concerning his residential placement, treatment plan, medical or financial plans.

W 124

At the time of the survey, there was no evidence that Client #2's treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, including the addition of Chlorpromazine 200 mg, had been explained to the client's guardian.

W 140 483.420(b)(1)(i) CLIENT FINANCES

The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.

W 140

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for two of two clients included in the sample. (Clients #1 and #2)

The finding includes:

W140

The QIDP will follow up with the travel agency to obtain actually receipts for the payment of the cruise both Client #1 and #2 attended...8-30-11  
MTS has established a monthly reconciliation meeting between the Client Accounts Coordinator and each Facility Manager to insure that there is routine auditing of client accounts monthly. This process will begin...9-1-11

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 140 Continued From page 4

The facility failed to provide evidence that justified the withdrawals/expenditures from Client #1 and #2's personal accounts, as evidenced below:

On July 28, 2011, at 12:58 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that Clients #1 and #2 went on vacation last year to the Bahamas. Further interview revealed that the facility assisted the clients' with maintaining their finances. Review of Clients #1 and #2's financial records on July 29, 2011, at approximately 10:34 a.m. and 4:03 respectively, revealed the following:

a. A tracking form entitled "Resident Fund Management Services Statement" revealed a withdrawal of \$899.00 was made from Client #1's account on October 1, 2010. Further review of the record revealed the \$899.00 in receipts and expenditures could not be accounted in the client's financial records.

b. A tracking form entitled "Resident Fund Management Services Statement" revealed a withdrawal was made from Client #2's account in the amount of \$600.00 for vacation and another withdrawal of \$100.00 for spending on October 1, 2010. Further review revealed there were no receipts and expenditures available for review at the time of the survey to justify the withdrawals.

Continued interview with the QIDP on July 28, 2011, at approximately 4:05 p.m., revealed that she did have receipts to justify the withdrawals for Clients #1 and #2. However, at the time of the survey, the receipts were not available for review.

W 140

W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 149 Continued From page 5

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 interview and record review, the facility's direct care staff failed to implement it's incident management policy for two of two clients residing in the facility. (Clients #1 and #2)

The finding includes:

1. [Cross Refer W153]. On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of two allegations of abuse from the Office of the Inspector General via e-mail. The e-mail revealed that on July 19, 2011, a confidential reporter called the Department on Disability Services (DDS) investigation unit and informed an investigator that Clients #1 and #2 was being abused by staff.

On July 27, 2011, at approximately 3:51 p.m., interview with the facility's incident management coordinator (IMC) revealed that on July 20, 2011, she discovered that there were two alleged allegations of abuse regarding Clients #1 and #2 while checking the MCIS system. Further interview revealed that she called DDS to confirm her findings with the investigator who entered the two allegations into the system. The IMC indicated that on July 19, 2011, DDS investigator received a telephone call from a confidential reporter that Staff #1 yelled at Client #2 using profanity and put his hands on him

W 149

W149

The Director of Residential Services has met with the IMC to insure that it is understood that MTS must report all incidents that involve individuals supported by MTS whether the initial reporting is done internally or externally. MTS will insure that DOH is notified about all incidents within 24 hours of becoming aware of the incident...8-30-11

MTS has established a protocol for tracking all incidents and investigations. The protocol tracks timely submission of initial incident reports and investigations, recognizing the 5-day timeline for those that must be submitted to DOH...8-24-11

This protocol will be rolled out for all management level staff and approved investigators by...9-10-11

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--	---------------	---	----------------------

W 149 Continued From page 6  
several times. The confidential reporter also indicated that Staff #2 yelled at Client #1 and hit him to make him use the bathroom.

When asked, the IMC stated that she did not report the two allegations of abuse to the Department of Health when she first discovered the allegations. According to the IMC, she was not aware that it was her responsibility to report the incidents to DOH, because she thought since the facility's staff did not report the allegations, DDS would take the responsibility to report them to DOH.

Interview with the facility's qualified intellectual disabilities professional (QIDP) on July 27, 2011, at approximately 3:01 p.m., revealed their incident management protocol for allegations of abuse was documented as follows:

- Staff should contact the police, QIDP, and House Manager (HM);
- HM or QIDP contacts the Administrator;
- IMC contacts the Department of Health (DOH);

Further interview with the QIDP revealed the facility had a written incident management policy. The QIDP provided a policy entitled "Incident Management and Enforcement Procedures." Review of policy included the following requirements pertaining to abuse, neglect or mistreatment reporting:

- Report the incident to supervisor immediately;
- Report to the administrator;
- Follow the instructions given by the supervisor;

W 149

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 149 Continued From page 7  
and  
- Complete an incident report.  
- Report to the Department of Health

W 149

At the time of the survey, the facility failed to provide evidence that the incident management policy was implemented as outlined.

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

W 153

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

This STANDARD is not met as evidenced by:  
Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all alleged allegations of abuse were reported immediately the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for two of two clients included in the sample. (Clients #1 and #2)

The finding includes:

(Cross refer W149) On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of three (3) allegations of physical and verbal abuse from the Office of the Inspector General via e-mail. The e-mail revealed that on July 19, 2011, a

W153

The Director of Residential Services has met with the IMC to insure that it is understood that MTS must report all incidents that involve individuals supported by MTS whether the initial reporting is done internally or externally. MTS will insure that DOH is notified about all incidents within 24 hours of becoming aware of the incident...8-30-11  
MTS has established a protocol for tracking all incidents and investigations. The protocol tracks timely submission of initial incident reports and investigations, recognizing the 5-day timeline for those that must be submitted to DOH...8-24-11  
This protocol will be rolled out for all management level staff and approved investigators by...9-10-11

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

PRINTED: 08/17/2011  
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  07/28/2011
--	--	--	--

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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 153 Continued From page 8  
confidential reporter called the Department on Disability Services (DDS) investigation unit and informed an investigator that Clients #1 and #2 were being verbally and physically abused by staff.

Review of the facility's incident report log book on July 27, 2011, beginning at 9:30 a.m., revealed there were no incident reports generated regarding the allegations of abuse that were reported on July 19, 2011.

On July 27, 2011, at approximately 3:51 p.m., interview with the facility's incident management coordinator (IMC) revealed that on July 20, 2011, she discovered that there were 3 alleged allegations of abuse regarding Clients #1 and #2 while checking the MCIS system. Further interview revealed that she called DDS to confirm her findings with the investigator who entered the two allegations into the system. The IMC indicated that on July 19, 2011, DDS investigator received a telephone call from a confidential reporter that Staff #1 yelled at Client #2 using profanity and put his hands on him several times. The confidential reporter also indicated that Staff #2 yelled at Client #1 and hit him until he used the bathroom.

When asked, the IMC stated that she did not report the two allegations of abuse to the Department of Health when she had first discovered the allegations.

At the time of the survey, there was no evidence the facility reported the two alleged allegations of abuse to DOH.

W 156 483.420(d)(4) STAFF TREATMENT OF

W 153

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 156 Continued From page 9  
CLIENTS

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.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to report the results of all investigations of alleged abuse to the administrator within five working days of the incident, for two of two clients included in the sample. (Clients #1 and #2)

The findings include:

(Cross refer W149) On July 27, 2011, at approximately 11:18 a.m., interview with the incident management coordinator (IMC) revealed that the assistant program director (APD) was assigned the responsibility of conducting the investigations regarding the alleged allegations of abuse for Clients #1 and #2.

On July 28, 2011, at approximately 11:55 a.m., and interview was conducted with the APD to ascertain information regarding the results of the investigations for the two allegations of abuse. Further interview with the APD revealed he had not started the investigation. According to the APD, he was unable to locate the paper work left by the IMC who was on vacation and would not return until the following week.

At the time of the survey, there was no documented evidence that the results of all investigations were reported to the administrator

W 156

W156

The Director of Residential Services has met with the IMC to insure that it is understood that MTS must report all incidents that involve individuals supported by MTS whether the initial reporting is done internally or externally. MTS will insure that DOH is notified about all incidents within 24 hours of becoming aware of the incident...8-30-11

MTS has established a protocol for tracking all incidents and investigations. The protocol tracks timely submission of initial incident reports and investigations, recognizing the 5-day timeline for those that must be submitted to DOH...8-24-11

This protocol will be rolled out for all management level staff and approved investigators by...9-10-11

The incident described has been investigated at this point and the report has been submitted to DOH (Attached to response document)...8-24-11

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 156 Continued From page 10  
within five working days of the allegations.

W 325 482.460(a)(3)(iii) PHYSICIAN SERVICES

The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of two clients included in the sample. (Client #2)

The finding includes:

On July 27, 2011, at 6:15 p.m., observation of the evening medication administration revealed that Client #2 was administered Topiramate 200 mg, Primidone 250 mg, and Clonazepam 4 mg by mouth. Interview with the facility's registered nurse (RN) on July 28, 2011, at approximately 1:35 p.m., revealed that the medications were prescribed for seizure disorder, depression, and maladaptive behaviors, respectively.

On July 28, 2011, beginning at 9:07 a.m., review Client #2's medical records revealed the client had diagnoses of intermittent explosive disorder, seizure disorder, inappropriate sexual disorder, depression, and aggression. Further review of the medical record revealed a physician's order (PO) dated June 2010 for the client to have Primidone, Topiramate, and Clonazepam

W 156  
W 325

W325

The RN has met with the DON who instructed the RN to use the standard, person-specific MTS Medical Activities Tracking Form to proactively track and schedule all medical appointments including serum lab work. The DON will have the forms submitted for review on a monthly basis and will insure that they are reviewed with the RN (for her caseload on) a routine, monthly basis...9-1-11

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
<p><b>W 325</b> Continued From page 11</p> <p>laboratory studies performed every three months. Subsequent review of the laboratory studies on the same day at 9:53 a.m., revealed there was no evidence of a laboratory study for September 2010. The December 15, 2010, laboratory studies revealed that the only medication tested during this study was Primidone. Additionally, there were no laboratory studies for June 2011 located in the records.</p> <p>Interview with the RN on July 28, 2011, at approximately 3:30 p.m., confirmed there was no evidence of laboratory studies for September 2010 and June 2011 located in the records. Further interview with the RN also confirmed Primidone was the only medication tested on December 15, 2010.</p> <p>At the time of the survey, there was no evidence that the routine laboratory studies were obtained as recommended by the physician.</p>	<p><b>W 325</b></p>			
<p><b>W 331</b> 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 review, the facility failed to ensure nursing services were provided in accordance with the needs for, two of four clients residing in the facility. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. Cross refer to W325. The facility's nursing staff failed to provide routine laboratory testing</p>	<p><b>W 331</b></p>	<p><b>W331</b></p> <ol style="list-style-type: none"> <li>1. The RN has met with the DON who instructed the RN to use the standard, person-specific MTS Medical Activities Tracking Form to proactively track and schedule all medical appointments including serum lab work. The DON will have the forms submitted for review on a monthly basis and will insure that they are reviewed with the RN (for her caseload on) a routine, monthly basis...9-1-11</li> <li>2. The RN has met with the medication passing nurse to reinforce the MTS protocol for medication passing, giving particular attention to the importance of maintaining medication in a secure manner at all times...8-24-11</li> </ol> <p>The RN will monitor medication passing at minimum once monthly to insure routine compliance...9-1-11</p>		

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 12 as determined necessary by the physician for Client #2.	W 331		
W 382	2. Cross refer to W382. The facility's nursing services failed to keep all drugs locked securely when not being prepared for administration. <b>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</b>  The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep all drugs locked securely when not being prepared for administration, for two of four clients residing in the facility. (Clients #1 and #3)</p> <p>The finding includes:</p> <p>On July 27, 2011, at approximately at 5:56 p.m., observation of the evening medication administration revealed the Licensed Practical Nurse (LPN) left Client #3's medications on a table near the surveyor while she walked upstairs. At 6:25 p.m., the LPN left Client #1's medications on a table near the surveyor while she left the client's bedroom to wash her hands. Interview with the facility's registered nurse (RN) on July 28, 2011, at 3:41 p.m., revealed that the LPN should have never left the medications unsecured.</p> <p>At the time of the survey, there was no evidence that each medication had been secured, except for when being prepared for administration.</p>	W382	<p>The RN has met with the DON who instructed the RN to use the standard, person-specific MTS Medical Activities Tracking Form to proactively track and schedule all medical appointments including serum lab work. The DON will have the forms submitted for review on a monthly basis and will insure that they are reviewed with the RN (for her caseload on) a routine, monthly basis...9-1-11</p>	

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>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)</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On July 27, 2011, at 11:03 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 AM and 12:00 AM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on July 27, 2011, beginning at 11:11 a.m., revealed that there were no fire drills available for review during the following time periods:</p> <p>a. Weekday morning shift from October 2010 to June 2011; b. Weekday evening shift from October to December 2011 and from April 2011 to June 2011 and; c. Weekday overnight shift from October 2010 to</p>	W 440	<p>W440</p> <p>The QIDP will insure that the 2011 MTS Fire Drill Schedule is followed on a routine monthly basis. The schedule insures that each shift has a drill on at minimum a quarterly basis. The QIDP will check the documentation record at minimum two days after the scheduled drill to insure that the drill occurred and was properly documented...9-1-11</p> <p>If a fire drill is not done or properly documented, the QIDP will insure that the fire drill is rescheduled within 5 days and implemented...9-1-11</p> <p>Purged fire drill records will be maintained in a standard, hanging folder in the home's office and in a cabinet designed for record-keeping.</p>	

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 440	Continued From page 14 December 2010.  In addition, there were no fire drills available for review during the 8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM shifts.  On July 28, 2011, at approximately 4:15 p.m., the QIDP revealed that she was unable to locate the purged fire drills records for the aforementioned fire drills.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills under varied conditions.  This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)	W 441		
	The finding includes:  On July 27, 2011, beginning at 11:11 a.m., review of the facility's fire drill records revealed that all available fire drills reviewed were conducted utilizing the front door exit. Interview with the qualified intellectual disabilities professional (QIDP) on July 27, 2011, at 11:03 a.m., revealed that the facility had at five methods of egress (front, back, side, basement, and garage door exits). Further review of the fire drill records revealed that the back, side, basement, and garage door exits had not been used since October 2010 for the available fire drills reviewed.	W441	The QIDP will hold a training session with staff to reinforce the importance of using all exits and the nearest exit during fire drills. Training will be implemented by...9-10-11 The QIDP will review fire drill documentation monthly to insure that all exits are appropriately used and will provide shift-specific training if not...9-15-11	

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 441 Continued From page 15  
On July 28, 2011, at approximately 4:15 p.m., the QIDP acknowledged that based on the fire drill documentation available, the aforementioned exits were not used during fire drills. There was no evidence on file at the time of survey to substantiate that all exits were used.

W 441

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2011
--	--	--	--

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
--------------------	--	---------------	---	--------------------

1 000	<p><b>INITIAL COMMENTS</b></p> <p>On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of three (3) allegations of physical and verbal abuse from the Office of the Inspector General, via e-mail. The email identified the following concerns:</p> <p><b>Allegation #1:</b> On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that while Resident #1 used the bathroom during shift change, Staff #2 yelled (pee, pee) and hit him until he used the bathroom. Conclusion: The allegation could not be substantiated.</p> <p><b>Allegation #2:</b> On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter regarding a physical injury to Resident #1's right eye. According the confidential reporter, allegedly on May 6, 2011, Resident #2 sustained a scratch underneath his eye and had a swollen face when Staff #3 hit the Resident for having a behavior. Conclusion: The allegation could not be substantiated.</p> <p><b>Allegation #2:</b> On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that Staff #1 yelled at Resident #2 using profanity and put his hands on him several times. Conclusion: The allegation could not be substantiated.</p> <p>Due to the nature of the alleged allegations, on July 27, 2011, an onsite investigation was initiated in conjunction with a recertification survey conducted from July 27, 2011 through July 28, 2011. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities.</p>	1 000		
-------	---	-------	--	--

Health Regulation & Licensing Administration  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1000	<p><b>INITIAL COMMENTS</b></p> <p>On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of three (3) allegations of physical and verbal abuse from the Office of the Inspector General, via e-mail. The email identified the following concerns:</p> <p>Allegation #1: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that while Resident #1 used the bathroom during shift change, Staff #2 yelled (pee, pee) and hit him until he used the bathroom. Conclusion: The allegation could not be substantiated.</p> <p>Allegation #2: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter regarding a physical injury to Resident #1's right eye. According the confidential reporter, allegedly on May 6, 2011, Resident #2 sustained a scratch underneath his eye and had a swollen face when Staff #3 hit the Resident for having a behavior. Conclusion: The allegation could not be substantiated.</p> <p>Allegation #2: On July 19, 2011, the DDS investigator received a telephone call from a confidential reporter who alleged that Staff #1 yelled at Resident #2 using profanity and put his hands on him several times. Conclusion: The allegation could not be substantiated.</p> <p>Due to the nature of the alleged allegations, on July 27, 2011, an onsite investigation was initiated in conjunction with a recertification survey conducted from July 27, 2011 through July 28, 2011. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities.</p>	1000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

STATE FORM

6899

277P11

If continuation sheet 1 of 11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
1000	<p>Continued From page 1</p> <p>The findings of the investigation and survey were based on observations and interviews with the staff and residents in the home and at one day program, interview with two guardians, as well as a review of the clinical and administrative records including incident/investigation reports.</p> <p>The results of the investigative and survey findings revealed that the state agency determined that the facility meet the Condition of Participation requirements in Governing Body, Client Protections and Facility Staffing by removing all alleged staff from resident contact pending the outcome of the investigation. The investigation, however, did substantiate the following:</p> <p>a) The facility failed to implement their incident management policy on reporting and investigating allegations of abuse;</p> <p>b) The facility the failed to report the alleged allegations to the DOH timely and;</p> <p>c) The facility failed to ensure that the results of all investigations were reported to the administrator within five working days.</p>	1000	
1082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group</p>	1082	<p>3503.10</p> <p>A cup dispenser will be put in place by...8-30-11</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
I 082	Continued From page 2  home failed to ensure all bathrooms were equipped with cup dispensers for four of the four residents residing in the facility.  The finding includes:  During the environmental inspection and interview with the Qualified Intellectual Disabilities Professional on July 28, 2011, beginning at 12:53 p.m., it was revealed that revealed the hallway bathroom utilized by the residents had cups sitting on the sink without a cup dispenser.  At the time of the survey, the facility failed to provide a cup dispenser in the hallway bathroom located on the first floor.	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 Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of four of four residents. (Residents #1, #2, #3, and #4)  The findings include:  On June 16, 2011, beginning at 3:15 p.m., the QIDP accompanied the surveyor to conduct observations of the environment. The following concerns were identified:	I 090	3504.1  1. The facility manager will spot check to insure that toothbrushes are properly stored and covered. Spot checks will occur at minimum 3 times weekly...9-1-11 The dresser drawers were placed back on track...8-1-11 The facility manager trained staff on proper storage of clothing (i.e. avoiding overstuffing of drawers)...8-24-11 2. Repainting of the home is scheduled to occur during a client vacation...10-15-11 3. Floor tiles will be replaced...10-15-11 The frying pans and pots have been discarded and replaced...8-14-11  The Assistant to the Residential Director has had his job description revised to reflect greater responsibility for home environmental upkeep and vehicle upkeep. The Assistant will audit home and vehicle upkeep on a routine monthly basis and will act as point person for scheduling needed follow up beginning...9-6-11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2011	
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
I 090	Continued From page 3  1. Resident #1's tooth brush was stored uncovered in his personal kit. Additionally, Resident #1's four dresser drawers were off tract, creating a potential safety hazard.  2. Observation of Resident #2 and #3's bedroom wall revealed peeling paint and dark marks. Additionally, the walls through out the facility were observed to be dirty and discolored.  3. The kitchen floor tiles were split in several places. The Teflon coating was peeling off of the bottom of one frying pan and two pots. Additionally, one of the handles was missing from one of the facility's pots.	I 090		
I 135	3505.5 FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for four of four residents residing in the GHPID. (Residents #1, #2, #3, and #4)  The finding includes:  The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:  On July 27, 2011, at 11:03 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated	I 135	3505.5  The QIDP will insure that the 2011 MTS Fire Drill Schedule is followed on a routine monthly basis. The schedule insures that each shift has a drill on at minimum a quarterly basis. The QIDP will check the documentation record at minimum two days after the scheduled drill to insure that the drill occurred and was properly documented...9-1-11  If a fire drill is not done or properly documented, the QIDP will insure that the fire drill is rescheduled within 5 days and implemented...9-1-11  Purged fire drill records will be maintained in a standard, hanging folder in the home's office and in a cabinet designed for record-keeping.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
I 135	<p>Continued From page 4</p> <p>shifts (8:00 AM - 4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the GHPID's fire drill log records on July 27, 2011, beginning at 11:11 a.m., revealed that there were no fire drills available for review during the following time periods:</p> <p>a. Weekday morning shift from October 2010 to June 2011;</p> <p>b. Weekday evening shift from October to December 2011 and from April 2011 to June 2011 and;</p> <p>c. Weekday overnight shift from October 2010 to December 2010.</p> <p>In addition, there were no fire drills available for review during the 8:00 AM - 8:00 PM and 8:00 PM - 8:00 AM shifts.</p> <p>On July 28, 2011, at approximately 4:15 p.m., the QIDP revealed that she was unable to locate the purge fire drills records for the aforementioned fire drills.</p>	I 135	
I 189	<p>3508.7 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall maintain records of residents' funds received and disbursed.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for two of</p>	I 189	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 189	<p>Continued From page 5</p> <p>two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>The GHPID failed to provide evidence that justified the withdrawals/expenditures from Resident#1 and #2's personal accounts, as evidenced below:</p> <p>On July 28, 2011, at 12:58 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that Clients #1 and #2 went on vacation last year to the Bahamas. Further interview revealed that the GHPID assisted the clients' with maintaining their finances. Review of Clients #1 and #2's financial records on July 29, 2011, at approximately 10:34 a.m. and 4:03 respectively, revealed the following:</p> <p>a. A tracking form entitled "Resident Fund Management Services Statement" revealed a withdrawal of \$899.00 was made from Resident#1's account on October 1, 2010. Further review of the record revealed the \$899.00 in receipts and expenditures could not be accounted in the client's financial records.</p> <p>b. A tracking form entitled "Resident Fund Management Services Statement" revealed a withdrawal was made from Resident#2's account in the amount of \$600.00 for vacation and another withdrawal of \$100.00 for spending on October 1, 2010. Further review revealed there were no receipts and expenditures available for review at the time of the survey to justify the withdrawals.</p> <p>Continued interview with the QIDP on July 28, 2011, at approximately 4:05 p.m., revealed that</p>	I 189	<p>3508.7</p> <p>The QIDP will follow up with the travel agency to obtain actually receipts for the payment of the cruise both Client #1 and #2 attended...8-30-11</p> <p>MTS has established a monthly reconciliation meeting between the Client Accounts Coordinator and each Facility Manager to insure that there is routine auditing of client accounts monthly. This process will begin...9-1-11</p>	

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

PRINTED: 08/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	<p>Continued From page 6</p> <p>several times. The confidential reporter also indicated that Staff #2 yelled at Client #1 and hit him to make him use the bathroom.</p> <p>When asked, the IMC stated that she did not report the two allegations of abuse to the Department of Health when she first discovered the allegations. According to the IMC, she was not aware that it was her responsibility to report the incidents to DOH, because she thought since the facility's staff did not report the allegations, DDS would take the responsibility to report them to DOH.</p> <p>Interview with the facility's qualified intellectual disabilities professional (QIDP) on July 27, 2011, at approximately 3:01 p.m., revealed their incident management protocol for allegations of abuse was documented as follows:</p> <ul style="list-style-type: none"> <li>- Staff should contact the police, QIDP, and House Manager (HM);</li> <li>- HM or QIDP contacts the Administrator;</li> <li>- IMC contacts the Department of Health (DOH);</li> </ul> <p>Further interview with the QIDP revealed the facility had a written incident management policy. The QIDP provided a policy entitled "Incident Management and Enforcement Procedures." Review of policy included the following requirements pertaining to abuse, neglect or mistreatment reporting:</p> <ul style="list-style-type: none"> <li>- Report the incident to supervisor immediately;</li> <li>- Report to the administrator;</li> <li>- Follow the instructions given by the supervisor;</li> </ul>	W 149	<p>The Director of Residential Services has met with the IMC to insure that it is understood that MTS must report all incidents that involve individuals supported by MTS whether the initial reporting is done internally or externally. MTS will insure that DOH is notified about all incidents within 24 hours of becoming aware of the incident...8-30-11</p> <p>MTS has established a protocol for tracking all incidents and investigations. The protocol tracks timely submission of initial incident reports and investigations, recognizing the 5-day timeline for those that must be submitted to DOH...8-24-11</p> <p>This protocol will be rolled out for all management level staff and approved investigators by...9-10-11</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 7  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 Intellectual Disabilities (GHPID) 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 two of two residents of the GHPID. (Residents #1 and #2)  The finding includes:  1. On July 21, 2011, at approximately 6:44 p.m., the Department of Health (DOH) received notification of two alleged allegations of abuse from the Office of the Inspector General via e-mail. The e-mail revealed that on July 19, 2011, a confidential reporter called the Department on Disability Services (DDS) investigation unit and informed an investigator that Residents #1 and #2 were being verbally and physically abused by staff.  Review of the GHPID's incident report log book on July 27, 2011, beginning at 9:30 a.m., revealed there was no incident reports generated regarding (for the incidents) the allegations of abuse that was reported on July 19, 2011.  On July 27, 2011, at approximately 3:51 p.m., interview with the GHPID's incident management coordinator (IMC) revealed that on July 20, 2011,	I 379		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
1379	<p>Continued From page 8</p> <p>she discovered that there were two alleged allegations of abuse regarding Residents #1 and #2 while checking the MCIS system. Further interview revealed that she called DDS to confirm her findings with the investigator who entered the two allegations into the system. The IMC indicated that on July 19, 2011, DDS investigator received a telephone call from a confidential reporter that Staff #1 yelled at Resident#2 using profanity and put his hands on him several times. The confidential reporter also indicated that Staff #2 yelled at Resident#1 and hit him until he used the bathroom.</p> <p>When asked, the IMC stated that she did not report the two allegations of abuse to the Department of Health when she had first discovered the allegations.</p> <p>At the time of the survey, there was no evidence the GHPID reported the two alleged allegations of abuse to DOH.</p> <p>2. On July 27, 2011, at approximately 9:57 a.m., review of an incident report revealed Resident #1 was involved in an incident dated January 18, 2011. According to the report, the resident fell in the facility's bathroom and hit his head on the bathroom door. Further review of the report revealed Resident #1 was transported to the emergency room where he was diagnosed with a closed head injury, and laceration to his scalp.</p> <p>At the time of the survey, there was no documented evidence the GHPID reported this incident involving Resident #1's fall.</p> <p>3. On July 27, 2011, at approximately 9:57 a.m., review of an incident report revealed Resident #1 was involved in an incident dated January 23,</p>	1379	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1379	Continued From page 9  2011. According to the report, Resident #1 had experienced loose stools and vomiting. The resident was transported to the emergency room and reportedly admitted. Interview with the facility's Registered Nurse, (RN) and review of the resident's medical record on July 27, 2011 at approximately 2:53 p.m. revealed the resident was discharged on January 31, 2011.  At the time of the survey, there was no documented evidence the GHPID reported this incident involving Resident #'s hospitalization.	1379		
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS  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.  This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure professional services that included 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 for one of two residents included in the sample. (Resident #2)  The finding includes:  On July 27, 2011, at 6:15 p.m., observation of the evening medication administration pass revealed that Client #2 was administered Topiramate 200	1401	3520.3  1. The RN has met with the DON who instructed the RN to use the standard, person-specific MTS Medical Activities Tracking Form to proactively track and schedule all medical appointments including serum lab work. The DON will have the forms submitted for review on a monthly basis and will insure that they are reviewed with the RN (for her caseload on) a routine, monthly basis...9-1-11	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4012 LEE STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	<p>Continued From page 10</p> <p>mg, Primidone 250 mg, and Clonazepam 4 mg by mouth. Interview with the facility's registered nurse (RN) on July 28, 2011, at approximately 1:35 p.m., revealed that the medications were prescribed for seizure disorder, depression, and maladaptive behaviors, respectively.</p> <p>On July 28, 2011, beginning at 9:07 a.m., review Client #2's medical records revealed the client had diagnoses of intermittent explosive disorder, seizure disorder, inappropriate sexual disorder, depression, and aggression. Further review of the medical record revealed a physician's order (PO) dated June 2010 for the client to have Primidone, Topiramate, and Clonazepam laboratory studies performed every three months. Subsequent review of the laboratory studies on the same day at 9:53 a.m., revealed there was no evidence of a laboratory studies for September 2010. The December 15, 2010, laboratory studies revealed that the only medication tested during this study was Primidone. There were no laboratory studies for June 2011 located in the records.</p> <p>Interview with the RN on July 28, 2011, at approximately 3:30 p.m., confirmed there was no evidence of laboratory studies for September 2010 and June 2011 located in the records. Further interview with the RN also confirmed Primidone was the only medication tested on December 15, 2010.</p> <p>At the time of the survey, there was no evidence that the routine laboratory studies were obtained as recommended by the physician.</p>	I 401		