

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

PRINTED: 03/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted on February 24, 2010 through February 26, 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 four clients was selected from a client population of eight males with various 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 day programs, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident/investigation reports.</p>	W 000	<p><i>Received 3/22/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 100 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 112	<p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep confidential information contained in each client's record, for eight of the eight clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8)</p> <p>The finding includes:</p> <p>On February 24, 25, and 27, 2010, a chart was observed posted openly on the bulletin board located in the kitchen. Review of the chart revealed that it included each client's full name and a listing of their prescribed diet. For example, Client #3 was prescribed a regular</p>	W 112	<p>All Clients' information will be kept confidential and contained in their records.</p>	3/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Constantine C. Reese* TITLE *Program Director* (X6) DATE *3/19/10*

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 112	Continued From page 1 calorie, mechanical soft double portion diet. The other clients also had specially prescribed diets. This practice failed to ensure the confidentiality of the client's personal information. On February 26, 2010, at 12:15 p.m., the House Manager acknowledged that the chart posted in the kitchen contained confidential dietary information.	W 112		
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. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients, guardians were informed of their risks and benefits of clients restrictive measures, for one of four clients included in the sample. (Client #3) The finding includes: The facility failed to ensure that informed consent was obtained from Client #3's guardian prior to the administration of his psychotropic medications. During the entrance conference on February 24, 2010, beginning at 9:30 a.m., the Qualified Mental Retardation Professional (QMRP) indicated that	W 124	QMRP will obtain consent from Client #3's legal guardian, for the use of Paxil CR 12.5mg. in the future, an informed consent will be obtained from client's guardian prior to the administration of psychotropic medications.	3/31/10

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W 124	<p>Continued From page 2</p> <p>Client #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Review of the client's current physician orders dated February 2010, on February 24, 2010, at approximately 11:00 a.m., revealed an order of Paxil CR 12.5 mg, by mouth, each morning. Interview with the Licensed Practical Nurse (LPN) on February 24, 2010, at 6:50 p.m., confirmed that the client received Paxil CR in the morning.</p> <p>The QMRP's statement was verified on February 25, 2010, at approximately 1:00 p.m., through review of Client #3's psychological assessment dated June 24, 2009. According to the assessment, Client #3 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process.</p> <p>Record verification on February 25, 2010, at 1:45 p.m., revealed that Client #3's guardian had given informed consent for the use of Haldol 5 mg QPM dated April 7, 2009. There was no consent signed, however, for the client's current Paxil CR 12.5 mg, by mouth, in the morning.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.</p>	W 124		
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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 the administration received the results of investigation the within five working days, for one of four clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on February 22, 2010, beginning at 9:45 a.m., revealed an incident involving Client #3. The incident dated March 1, 2009, revealed that staff discovered an abrasion on his nose and bottom lip.</p> <p>Review of the corresponding investigative report revealed that the Incident Management Coordinator (IMC) completed the investigation. The administrator signed the investigative results; however there was no date. There was no evidence that the results of the investigation were reported by the administrator within five working days of the incident.</p>	W 156	<p>In the future, the results of all investigations will be reported to the administrator within five working days of all incidents. Administrator will sign and date incidents at the time of review.</p>	3/22/10
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a</p>	W 159		

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W 159	<p>Continued From page 4 qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for eight of the eight clients' in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross refer to W112. The QMRP failed to keep confidential information contained in each client's record. 2. Cross refer to W189. The QMRP failed to ensure staff received effective training while conducting fire drills under various conditions. 3. Cross refer to W240. The QMRP failed to ensure that there were interventions/strategies to address Client #1's maladaptive behavior (running through the house) in the Behavior Support Plan. 4. Cross refer to W247. The QMRP failed to ensure that clients' were provided opportunities for making choices as a part of their self-management. 5. Cross refer to W249. The QMRP failed to ensure the consistent implementation of Client #1's Behavior Support Plan. 6. Cross refer to W252. The QMRP failed to ensure the implementation of an effective system of documenting Client #1's Individual Program 	W 159	<ol style="list-style-type: none"> 1. Cross reference W112 2. cross reference W189 3. Cross reference W193 4. Staff will receive training on giving clients opportunities to make choice selections. QMRP will monitor to ensure that all clients are given the opportunity to make choices. 5. Cross reference W193 6. Cross reference W252 	<p>3/22/10</p> <p>3/31/10</p> <p>3/31/10</p> <p>3/31/10</p> <p>3/31/10</p> <p>3/31/10</p>
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W 159	Continued From page 5 Plans. 7. Cross refer to W325. The QMRP failed to ensure nutrition recommendations were addressed. 8. Cross refer to W441. The QMRP to ensure the facility conducted fire drills under varied conditions. 9 Cross refer to W460. The facility QMRP failed to ensure that nutritional training had been effective for staff that prepared Client #1's meals and snacks.	W 159		
			7. Cross reference W325	3/31/10
			8. Cross reference W441	3/31/10
			9. Cross reference W460	3/31/10
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure effective training had been provided that enabled the employee to perform his or her duties effectively, efficiently and competently for eight out of eight clients in the facility. (Client #1, #2, #3, #4, #5, #6, #7, and #8) The findings include: 1. Cross Refer to W252. Review of the facility's In-service training record on February 26, 2010, at approximately 11:15 a.m., revealed all staff had received training on documentation dated January 15, 2010.	W 189		
			Cross reference W252	3/31/10

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W 189	Continued From page 6 2. Cross Refer to W441. The facility failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for one of the four clients in the sample. (Client #1) The finding includes: Cross-refer to W249. During the observations on February 24, 2010, from 10:22 a.m., to 6:35 p.m., Client #1 was observed to exhibit maladaptive behaviors (i.e. running through the facility, grabbing others clothes and kicking). Although the client was redirected several times, the staff failed to implement the treatment strategies that were outlined in the client's BSP. Review of the staff training records on February 26, 2010, at approximately 10:35 a.m., revealed that all staff had received training for Client #1's BSP on November 3, 2009. Observations on February 24, 2010, however, indicated that the training had not been effective.	W 193	Behavioral Specialist will train Direct Care Staff on the implementation of treatment strategies outlined in the Behavior Support Plan for Client #1. In the future, QMRP and House Manager will monitor the implementation of Clients' behavior support plan.	3/31/10
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 212		

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W 212	<p>Continued From page 7</p> <p>Identify the presenting problems and disabilities and where possible, their causes.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client who received psychotropic medications, had a psychiatric assessment, for one of the four clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Observation of the evening medication administration on February 24, 2010, at 6:50 p.m., revealed Client #2 received Haldol 5 mg. Interview with the licensed practical nurse (LPN), after the medication administration indicated that the medication was prescribed for behavior management. Review of the client's current physician orders dated February 2010, on February 24, 2010, at approximately 11:00 a.m., revealed an order of Paxil CR 12.5 mg, by mouth, each morning. Interview with the LPN on February 24, 2010, at 6:50 p.m., confirmed that the client received Paxil CR in the morning.</p> <p>Review of Client #3's physicians orders dated February 2010, on February 25, 2010, at 11:00 a.m., revealed that the aforementioned medications were incorporated in a Behavior Support Plan (BSP) dated June 24, 2009.</p> <p>Review of Client #3's medical evaluation dated June 5, 2009, on February 24, 2010, at 1:50 p.m., revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of a psychotic disorder.</p>	W 212	<p>Client #3 will be assessed by his psychiatrist. In the future, QMRP will ensure that each client receiving psychotropic medications will have a psychiatric assessment.</p>	4/20/10

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W 212	Continued From page 8 Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.	W 212		
W 240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that there were interventions/strategies to address a client's maladaptive behavior (running through the house) in the Behavior Support Plan (BSP), for one of the four clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observations conducted on February 24, 2010, at 12:40 p.m., Client #1 was observed to leave the dining table and ran toward the administrator's office. Direct Care Staff #1 (DCS) who was providing 1:1 supervision during this time verbally prompted the client to come back to the table. At 12:50 p.m., Client #1 left his seat again and ran through the living room area into the administrator's office. He was verbally redirected from a different 1:1 female staff that remained in the dining area. On February 25, 2010, at 3:57 p.m., Client #1 was observed to run into the administrator's office from the living room area and grabbed the House Manager's shirt. He was verbally redirected from by staff to go back to the dining area.</p> <p>Interview with the Client #1's 1:1 staff on February 25, 2010, at approximately 3:00 p.m., revealed</p>	W 240	<div style="border: 1px solid black; padding: 2px;">Cross reference W193</div>	<div style="border: 1px solid black; padding: 2px;">3/31/10</div>

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W 240	Continued From page 9 Client #1 had a targeted behavior of running through the house that was addressed in his Behavior Support Plan (BSP). Review of the BSP dated October 14, 2009, on February 25, 2010, at 11:45 a.m., confirmed the BSP identified the client had a behavior of running around the house without a purpose. However, there were no strategies/interventions for direct care staff to follow when the maladaptive behavior of running through the house occurred.	W 240		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff implemented clients' Behavior Support Plans (BSP), for one of the four clients included in the sample (Client #1) and failed to ensure staff implemented clients feeding program, for one of four clients included in the sample. (Client#1) The findings include: 1. Observations conducted on February 24, 2010, beginning from 10:22 a.m. to 4:00 p.m., revealed staff failed to implement Client #1's BSP as follows:	W 249	Cross reference W193	3/31/10

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W 249	<p>Continued From page 10</p> <ul style="list-style-type: none"> - At 12:40 p.m., Client #1 left the dining table and ran toward the administrator's office. Direct Care Staff #1 (DCS) who was providing 1:1 supervision during this time, verbally prompted the client to come back to the table. - At 12:50 p.m., Client #1 left his seat again and ran through the living room area into the administrator's office. He was verbally redirected from a different 1:1 female staff that remained in the dining area. - At 3:18 p.m., Client #1's housemates was observed to arrive home from day program. - At 3:40 p.m., Client #1 was observed to pull on Client #5's shirt. Client #5 vocalized a loud sound and staff (who was not in close proximity) immediately redirected Client #1 to let go of his shirt. After the redirecting, Client #1 was observed to remove his shirt from his body. A minute later, Client #1 walked over to the dining area, knocked a sponge ball to the floor, and then walked over to the surveyor and grabbed his sweater tightly. Again the staff was not in close proximity to the client. The House Manager intervened by verbally redirecting the client 5 times to let go of the surveyor's shirt. - At 3:50 p.m. and 3:55 p.m., Client #1 was observed taking off his shirt and receiving verbal prompts from a different staff in the area to put his shirt back on. - Continued observations from 4:00 p.m. to 6:35 p.m., revealed Client #1 received 1:1 supervision indirectly from at least four (4) different staff. - At 4:22 p.m., Client #1 grabbed Client #4's shirt 	W 249		
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W 249	<p>Continued From page 11</p> <p>while engaged in tabletop activities with his peers at the dining table. A Direct Care Staff (DCS) was observed to move a chair between Client #1 and his peers to prevent him from grabbing other peers.</p> <p>- At 4:30 p.m., Client #1 walked over to the surveyor and kicked him 2 times on the left lower leg softly before being redirected by DCS.</p> <p>- At 4:37 p.m., Client #1 walked over to Client #6 in the living room area and began pulling on his clothes. DCS was observed in the dining area, kitchen, and administrative office.</p> <p>On February 24, 2010, at approximately 10:30 a.m., interview with the Direct Care Staff (DCS) revealed that she was providing 1:1 supervision for Client #1 along with another DCS to manage maladaptive behaviors (i.e. refusals to get on/off van, any other refusal with staff direct request, self-stimulatory, non-dangerous, running around the house, inappropriate public sexual behaviors, pica, self-injurious behaviors, aggression to others (grabbing/kicking), property destruction, and food refusals).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 25, 2010, at approximately 11:00 a.m., revealed that two female staff were providing 1:1 supervision during the 8 AM to 4 PM shift. Further interview revealed that one of the major duties for the assigned staff working with Client #1, was to supervise him closely at all times.</p> <p>Review of Client 1#'s BSP dated October 14, 2009, on February 26, 2010, at 11:45 a.m., confirmed the DCS and QMRP's interview. Further review of the BSP revealed that when</p>	W 249		
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W 249	Continued From page 12 Client #1 grabs others or grabs their clothes, then staff should intervene. "The sooner, the better as Client #1 tends to escalate, make a tighter and tighter grip." The BSP also stated to verbally redirect the client to do something else with his hands. There was no evidence that on February 24, 2010, that the facility staff demonstrated competency in the implementation of the client's BSP.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the four clients in the sample. (Client #1) The finding includes: Evening observations conducted on February 24, 2010, at approximately 4:20 p.m., Client #1 was observed engaged in table top activities (i.e. identifying shapes, colors, numbers, games, etc) with his peers at the dining table. Further observation at 4:35 p.m., Client #1 was observed in the living room with staff identifying the alphabet and more numbers. Interview with the Direct Care Staff (DCS) on the same day at approximately 4:50 p.m., revealed that tabletop activities and interacting with his peers was part of his active treatment programs.	W 252	Direct Care Staff will receive training on program implementation and documentation. QMRP and House Manager will monitor program documentation weekly.	3/31/10

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W 252	<p>Continued From page 13</p> <p>Record verification of Client #1's Individual Program Program (IPP) dated November 9, 2009, on February 26, 2010, at 10:54 a.m., revealed the client had one IPP that stated "given the appropriate level of assistance, the client will play games related to colors, numbers, or shapes daily".</p> <p>Review of the data sheet on the same day at approximately 11:00 a.m., revealed no documentation for the date of February 24, 2010. Further review of the data sheets for the month of January 2010, revealed the program was not documented on 8 of 31 days. For the month of December 2009, the program was not documented 15 out of the 31 days. Interview with the Qualified Mental Retardation Professional on February 26, 2010, at 12:30 p.m., acknowledged that direct care staff were not documenting the program as indicated.</p> <p>There was no evidence that the data was collected in accordance with the IPP for the client, which was necessary for a functional assessment of the client's progress.</p>	W 252		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure restrictive measures were being implemented with the</p>	W 263	Cross reference W124	3/31/10

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W 263	<p>Continued From page 14</p> <p>written consent of the client's court appointed legal guardian, for one of the four included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility failed to ensure that written consent was obtained from Client #3 court appointed legal guardian prior to the administration of his psychotropic medications and Behavior Support Plan (BSP).</p> <p>During the entrance conference on February 24, 2010, beginning at 9:30 a.m., the Qualified Mental Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observation of the evening medication administration on February 24, 2010, at 8:50 p.m., revealed Client #3 received Haldol 5 mg. Interview with the LPN on February 24, 2010, at 8:50 p.m., indicated that the client received Paxil CR in the morning. Review of the client's current physician orders dated February 2010, on February 24, 2010, at approximately 11:00 a.m., confirmed the LPN's statement that the client was prescribed Paxil CR 12.5 mg, by mouth, each morning.</p> <p>The QMRP's statement was verified on February 25, 2010, at approximately 1:00 p.m., through review of Client #3's psychological assessment dated June 24, 2009. According to the assessment, Client #3 "does not show competency or intellectual capacity to make</p>	W 263		
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W 263 Continued From page 15
independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters." Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process.

Record verification on February 25, 2010, at 1:45 p.m., revealed that Client #3's guardian had given informed consent for the use of Haldol 5 mg QPM dated April 7, 2009. However there was no written consent signed for the client's Paxil 12.5 mg, by mouth, in the morning.

At the time of the survey, the facility failed to provide evidence ensure consent was obtained for the use of psychotropic medication and the BSP.

that the potential risks involved in using the medications, or Client #'s right to refuse treatment had been explained to the client and/or legal sanction representative.

W 263

W 322 483.460(a)(3) PHYSICIAN SERVICES

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's primary care physician (PCP) failed to ensure that client's nutritionist recommendations were addressed, for one of the four clients included in the sample. (Client #3)

The finding includes:

W 322

The primary care physician will ensure the Client #3 nutritionist recommendations are addressed on the physicians orders. Primary nurse will review physicians orders monthly to ensure nutrition recommendation are addressed.

4/1/10

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W 322 Continued From page 16

On February 24, 2010, beginning at 5:31 p.m., Client #3 was observed to received double portion baked chicken, butter noodles, turnip greens finely chopped, and beverage during dinner time. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 5:00 p.m., revealed Client #3 was prescribed a double portion mechanically soft diet. It should be noted that the dinner was prepared by the QMRP.

Review of Client #3's current physician orders dated February 2010, on February 25, 2010, at 10:00 a.m., revealed a diet order for a regular high calorie diet. Review of the Client #3's nutritionist assessment dated June 30, 2009, on the same day, recommended that the client receive a regular high calorie, mechanically soft double portion diet. Review of the Client #3's swallowing function assessment dated July 14, 2008, on February 25, 2010, at approximately 11:00 a.m., indicated that the client should receive a mechanically soft chopped food texture with moisture to ensure bolus cohesion.

Interview with the nurse revealed that he was unaware of the recommendation. Record review of the client's medical progress notes and physician's order failed to address the Nutrition's recommendation.

W 322

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.

W 325 Client #4 will receive laboratory testing for tegretol studies. In the future, Nursing Staff will ensure routine laboratory testing as recommended by the primary care physician.

3/22/10

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W 325	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility's nursing staff failed to ensure routine laboratory testing as determined necessary by the primary care physician (PCP), for one of the four clients included in the sample. (Client #4)</p> <p>The finding includes:</p> <p>Observations during the medication administration on February 24, 2010, at 6:50 p.m., revealed Client #4 was observed receiving Divaproex SOD sprinkle 125 mg. Review of Client #4's medical evaluation dated August 7, 2009, on February 24, 2010, at 11:14 a.m., revealed diagnoses of seizure disorder.</p> <p>Review of Client #4's medical record on February 24, 2010, at 11:30 a.m., revealed physician's orders dated February 2010, August, 2009, for tegretol laboratory studies to be performed every six months. Further review of the client's medical records at approximately 11:45 a.m., revealed the last documented laboratory studies for the tegretol studies were dated July 21, 2009.</p> <p>In an interview with the Registered Nurse (RN) on February 25, 2010, at approximately 10:15 a.m., it was acknowledged the tegretol laboratory studies had not been performed quarterly as recommended by the PCP.</p> <p>There was no evidence the routine laboratory testing was obtained as recommended by the physician.</p>	W 325	<p>The primary nurse for the facility will review physician's order on a monthly basis to ensure orders are carried out. Client #4 Tegretol level will be done on 3/22/10.</p>	3/22/10
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT	W 356		

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W 356	Continued From page 18 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 comprehensive treatment services for the maintenance of dental health, for one of the four clients in the sample. (Client #4) The finding includes: Review of Client #4's medical record on February 24, 2010, at approximately 11:17 a.m., revealed a dental consultation dated December 17, 2008. The dentist noted that the client had moderate calculus deposits and needed scaling under anesthesia. Further review revealed an additional dental consultation form dated September 1, 2008. The consultation forms revealed moderate calculus deposits and recommended scaling on the next visit. Interview with the registered nurse (RN) on February 25, 2010, at approximately 11:00 a.m., revealed that the client needed consent prior to returning to the dentist school for scaling under anesthesia. At the time of the survey, the facility failed to ensure Client #4 received timely dental services (scaling).	W 356	QMRP will contact Resident #4's Service Coordinator at DDS and request assistance for obtaining legal guardianship and consent for Resident #4 to receive scaling under anesthesia.	4/30/10
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that ensured the recommended adaptive equipment was purchased, for one of the four clients included in the sample. (Client #3 and #4) The findings include: 1. The facility failed to ensure that Client #3 received the recommended adaptive equipment (sipper cup and universal cuff). During meal observations on February 24, 2010, at 3:30 p.m., Client #3 was observed using a scoop plate, plate guard, weighted spoon, and regular cup. As the client consumed his beverage, the liquid was observed running out of his mouth, down his chin and onto his clothes. Again at 5:40 p.m., during dinner observations, Client #3 was observed using a regular cup. The client required hand over hand assistance, as he consumed his beverage. The liquid was observed running out of his mouth, down his chin and onto his clothes. The direct care staff was observed taking the client upstairs. Ten minutes later, the client returned with a dry shirt on. During medication administration on February 22, 2010, at 6:50 p.m., the licensed practical nurse (LPN) was observed using a regular cup while pouring the liquid into the client's mouth. The LPN took his time and there was no observed spillage. Interview with Client #3's one to one support staff revealed that the client required hand over hand	W 436	1. Universal cuff and sipper cup will be purchased for Client #3 as recommended. CMS Management Staff will also review policy on adaptive equipment for individuals.	4/31/10

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W 436	<p>Continued From page 20 assistance during meals.</p> <p>Review of the Client #3's swallowing function assessment dated July 14, 2008, on February 25, 2010, at approximately 11:00 a.m., indicated that the client should continue with thin liquids using a sipper cup. He should continue to have feeding assistance. According to the Individual Support Plan (ISP) dated June 29, 2009, on February 23, 2010, at 11:30 a.m., revealed the following adaptive equipment: leg braces, gait belt, scoop plate, plate guard and sipper type cup, etc....</p> <p>Interview with the house manager and QMRP on on February 25, 2010, at approximately 10:00 a.m., revealed that the client does not have a universal cuff and they were not aware of such an adaptive feeding equipment.</p> <p>Interview with Developmental Disabilities Case Manager on February 25, 2010, at approximately 11:10 a.m., indicated no knowledge of Client #3's adaptive equipment (universal cuff).</p> <p>At the time of the survey, the facility failed to ensure Client #3 was provided with the recommended sipper cup and universal cuff.</p> <p>2. The facility failed to ensure that Client #3 received the recommended helmet with face guard.</p> <p>Review of the facility's incident and investigative reports on February 24, 2010, beginning at 9:45 a.m., revealed several incidents where Client #3 fell and sustained injuries to his face.</p> <p>- On July 12, 2009, Client #3 attempted to get up</p>	W 436	<p>2. Client #3 will be measured by the physical therapist for a helmet that includes a face guard.</p>	3/31/10

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W 436	Continued From page 21 from the couch. the client lost his balance and hit his face on the floor. He sustained swelling of his lower lip. - On October 15, 2009, staff was assisting Client #3 with personal hygiene skills (lotioning his body). The client lost his balance and hit his face on the bathroom radiator. He sustained facial lacerations. Observations throughout the survey, from February 24, 2010, through February 26, 2010, Client #3 was observed wearing a skull hat with his helmet on top. The helmet was observed sitting on the bridge of the client's nose. Interview with Client #3's one to one support on February 24, 2010, at 3:15 p.m., indicated that the helmet was "blg and putting the skull cap underneath the helmet, allowed the helmet to fit better." Interview with the house manager and qualified mental retardation professional (QMRP) on February 25, 2010, at approximately 10:00 a.m., revealed that the client wears the helmet for protections from falls. Further interview indicated that the helmet should be worn at all times, with the exception of bathing and sleeping. Review of the medical record on February 25, 2010, at approximately 12:15 p.m., revealed a medical necessity letter dated July 31, 2010. The letter indicated that although [the client] has a protective helmet worn during waking hours he still incurs injuries on his face. It is recommended for him to use e helmet with a face guard/safety guard. Further review of the record revealed a physical therapy (PT) note dated March 3, 2009.	W 436		

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W 436	Continued From page 22 The PT note indicated that although the client wears a helmet he continues to sustain injuries to his face. According to the PT note, it was recommended that a new helmet with a safety guard be purchased. At the time of the survey, the facility failed to obtain the helmet with a safety guard.	W 436			
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 the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on one of three shifts of drills reviewed. (8 AM to 4 PM shift) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on February 24, 2010, approximately 9:45 a.m., revealed the facility had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. A review of the fire drill reports from March 2009 to February 2010 was conducted on February 24, 2010, at 9:48 a.m. Further review of the fire drill reports from March 2009 to May 2009 and September 2009 to November 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM shift during the week. Interview with the QMRP on the same day at 10:17 a.m., acknowledged that no fire drills	W 440	Staff working from 8am to 4pm will receive training on evacuation drills. In the future, QMRP and House Manager will monitor evacuation drill record monthly to ensure that drills are held at least quarterly for each shift.	3/21/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(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 23 were conducted during the 8 AM to 4 PM shift for these periods during the week. At the time of the survey, there was no documented evidence that fire drills were conducted quarterly as required.	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) The finding includes: Review of the facility's fire drill records on February 24, 2010, at 9:48 a.m., revealed staff documented having evacuated clients via the front, side, and basement door exits on all drills. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:17 a.m. revealed that the facility's emergency fire evacuation plan included 5 emergency exits, including a back door exit through the kitchen. After looking through the fire drill log book, the QMRP acknowledged that the back door fire exit had not been used during drills within the past year.	W 441	Staff will receive training on evacuation drills under varied conditions. QMRP and House Manager will monitor evacuation drill records to ensure that drill are held under varied conditions.	3/31/10	
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specialty-prescribed diets.	W 460	Staff will receive training by the nutritionist on the prescribed diet for Client #1. QMRP and House Manager will monitor during the preparation of meals to ensure prescribed diets are being adhered to.	3/31/10	

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

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 15TH STREET NW WASHINGTON, DC 20010
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W 460	<p>Continued From page 24</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide a nourishing, well-balance diet, for one of the three residents included in the sample. (resident #1)</p> <p>The findings include:</p> <p>1. On February 24, 2010, at 12:30 p.m., resident #1 prepared a bologna (2 pieces of meat) sandwich on white bread with mustard with some physical assistance from staff for lunch. Moments later, the resident was also given a bowl of ramen noodles and two pop tarts for snack.</p> <p>Interview with resident #1's 1:1 staff on February 26, 2010, at approximately 10:45 a.m., revealed that there were lunch menus on the weekends. Further interview with the 1:1 staff revealed that she was unsure if there were lunch menus for weekdays. The 1:1 staff stated that, "I would have to ask the Qualified Mental Retardation Professional (QMRP)." Interview with the QMRP on the same day at approximately 12:40 p.m., revealed there were weekly lunch menus. The QMRP provided the surveyor with the menu for the week of February 21, 2010 through February 27, 2010. When asked if there were any menu substitutions for the day of February 24, 2010, the 1:1 staff stated, "No."</p> <p>Review of the February 24, 2010, menus at approximately 12:43 p.m., on the same day revealed that the lunch menu consisted of a fish sandwich, French fries, pineapple, and fruit juice.</p> <p>There was no evidence that substitutions made for the planned menu items were of similar nutritional value.</p>	W 460		
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W 460	Continued From page 25 2. On February 24, 2010, at 12:30 p.m., resident #1 was observed to prepare a bologna (2 pieces of meat) sandwich between two pieces of white bread with mustard and bowl ramen noodles for lunch. Moments later, the resident was observed eating two pop tarts for snack. At 3:42 p.m., resident #1 was observed eating peanuts for snack. Observations of the dinner meal at 5:40 p.m., revealed resident #1 received baked chicken, butter noodles, turnip greens, a piece of toasted white bread, reduce milk, and water for dinner. resident #1 consumed 100% of his meal and was given more butter noodles and another piece of baked chicken. Interview with direct care staff after resident #1's dinner meal at approximately 8:00 p.m., revealed resident #1 was on a regular diet. On February 25, 2010, at approximately 12:50 p.m., interview with the QMRP and review of the resident #1's Physician's Orders dated February 2010, confirmed that resident #1 was on a regular diet. Review of resident #1's nutritional assessment dated October 6, 2009, on February 25, 2010, at 12:52 p.m., revealed the resident had a weight gain of 30 pounds over the past year. The resident's Ideal Body Weight (IBW) was 130 lbs - 142 lbs. Further review of the assessment recommended a regular diet with single servings and an exercise program. Review of the Medication Administration Record (MAR) on February 26, 2010, at approximately 1:00 p.m., revealed resident #1 currently weighed 159 lbs (17 pounds over his IBW).	W 460			

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W 480	Continued From page 26 At the time of the survey, there was no evidence that resident #1 received single servings of food as recommended by the Nutritionist.	W 480		

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R 000	INITIAL COMMENTS A licensure survey was conducted on February 24, 2010, through February 26, 2010. Due to systemic deficient practices identified during the 2008 recertification survey, the State Agency determined that the full survey process would be utilized. A random sample of four residents was selected from a resident population of eight males with various disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with staff in the home and day programs, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident/investigation reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT 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. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP 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 four of the twelve staff employed. The finding includes: On February 25, 2010, beginning at 1:45 p.m., review of personnel records revealed Review of	R 125	Staff #1, #3 and #4 will obtain a criminal background check that will disclose the criminal history for the previous seven years. In the future, QMRP and House Manager will ensure that each employee meets background check requirements.	3/25/10

Health Regulation Administration
Constantine A. Reese
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 STATE FORM

TITLE
Program Director
 (X6) DATE
 3/19/10
 If continuation sheet 1 of 2

07QZ11

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R 125	Continued From page 1 the personnel files on March 7, 2007 revealed the GHMRP failed to evidence criminal background checks for the four of the staff. (Staff #1, #3, #4 and #5)	R 125	
(X5) COMPLETE DATE			

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1 000 INITIAL COMMENTS

A licensure survey was conducted on February 24, 2010 through February 26, 2010. Due to systemic deficient practices identified during the 2008 recertification survey, the State Agency determined that the full survey process would be utilized. A random sample of four residents was selected from a resident population of eight males with various disabilities.

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

1 000

1 040 3502.1 MEAL SERVICE / DINING AREAS

Each GHMRP shall provide each resident with a nourishing, well-balanced diet.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the Group Home for Mentally Retarded Person (GHMRP)GHMRP failed to provide a nourishing, well-balance diet for one of the three residents included in the sample. (Resident #1)

The finding includes:

On February 24, 2010, at 12:30 p.m., Resident #1 prepared a bologna (2 pieces of meat) sandwich on white bread with mustard with some physical assistance from staff for lunch. Moments later, the resident was also given a bowl of ramen oodles and noodles and two pop tarts for snack.

1 040

Staff will receive training by the nutritionist on the prescribed diet for Resident #1. QMRP and House Manager will monitor during the preparation of meals to ensure prescribed diets are being adhered to.

3/31/10

Health Regulation Administration
Christine A. Reese
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Program Director

(X6) DATE
3/19/10

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I 040	Continued From page 1 Interview with Resident #1's 1:1 staff on February 26, 2010, at approximately 10:45 a.m., revealed there were lunch menu's during the weekends. Further interview with the 1:1 staff revealed that she was unsure if there were lunch menus for during the week. The 1:1 staff stated that I would have to ask the Qualified Mental Retardation Professional (QMRP). Interview with the QMRP on the same day at approximately 12:40 p.m., revealed there were weekly lunch menus. The QMRP provided the surveyor with the menu for the week of February 21, 2010 through February 27, 2010. When asked if there were any menu items that required substitutions for the day of February 24, 2010, the 1:1 staff stated no. Review of the February 24, 2010 menu at approximately 12:43 p.m., on the same day revealed that the lunch menu consisted of a Fish sandwich, French fries, pineapple, and fruit juice. There was no evidence that substitutions made for the planned menu items were of similar nutritional value.	I 040		
I 054	3502.12 MEAL SERVICE / DINING AREAS Residents shall be provided training to develop eating skills and to use special eating equipment and utensils if such training is indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Mentally Retarded Person (GHMRP) failed to ensure residents were provided training to develop eating skills, for one of four residents included in the sample. (Resident #3)	I 054		

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I 054	<p>Continued From page 2</p> <p>The findings include:</p> <p>The GHMRP failed to ensure that Resident #3 received the recommended adaptive equipment (sipper cup and universal cuff).</p> <p>During meal observations on February 24, 2010, at 3:30 p.m., Resident #3 was observed using a scoop plate, plate guard, weighted spoon, and regular cup. As the Resident consumed his beverage, the liquid was observed running out of his mouth, down his chin and onto his clothes. Again at 5:40 p.m., during dinner observations, Resident #3 was observed using a regular cup. The Resident required hand over hand assistance, as he consumed his beverage. The liquid was observed running out of his mouth, down his chin and onto his clothes. The direct care staff was observed taking the Resident upstairs. Ten minutes later, the Resident returned with a dry shirt on. During medication administration on February 22, 2010, at 6:50 p.m., the licensed practical nurse (LPN) was observed using a regular cup while pouring the liquid into the Resident's mouth. The LPN took his time and there was no observed spillage.</p> <p>Interview with Resident #3's one to one support staff revealed that the Resident required hand over hand assistance during meals.</p> <p>Review of the Resident #3's swallowing function assessment dated July 14, 2008, on February 25, 2010, at approximately 11:00 a.m., indicated that the Resident should continue with thin liquids using a sipper cup. He should continue to have feeding assistance. According to the individual Support Plan (ISP) dated June 29, 2009, on February 23, 2010, at 11:30 a.m., revealed the</p>	I 054	<p>Universal cuff and sipper cup will be purchased for Client #3 as recommended. In the future, QMRP will ensure all recommendations for adaptive equipment are received.</p>	4/30/10
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I 054	Continued From page 3 following adaptive equipment: leg braces, gait belt, scoop plate, plate guard and sipper type cup, etc.... Interview with the house manager and QMRP on on February 25, 2010, at approximately 10:00 a.m., revealed that the Resident does not have a universal cuff and they were not aware of such an adaptive feeding equipment. Interview with Developmental Disabilities Case Manager on February 25, 2010, at approximately 11:10 a.m., indicated no knowledge of Resident #3's adaptive equipment (universal cuff). At the time of the survey, the GHMRP failed to ensure Resident #3 was provided with the recommended sipper cup and universal cuff.	I 054		
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 the Mentally Retarded (GHMRP) failed to ensure the interior of the GHMRP was maintained in a clean, orderly, attractive, and sanitary manner, for eight of eight residents included residing in the facility. (Residents #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: An environmental inspection conducted on	I 090		

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I 090	<p>Continued From page 4</p> <p>February 26, 2010, beginning at 1:20 p.m. revealed the following:</p> <ol style="list-style-type: none"> 1. Resident #8 had chipped paint over his headboard. 2. Residents #1 and #5 bedroom had chipped paint in the window sill and on the radiator covers. 3. The stove had burnt on food debris on the burners. 4. The second floor bathroom tub was in need of regrouting. 5. The second floor bathtub was rusted. 6. The third floor bathroom had missing tiles on the wall. 	I 090	<ol style="list-style-type: none"> 1. Wall over Resident #8's headboard will be repainted. 2. Window sill and radiator covers in resident #1 and #5's bedroom will be repainted. 3. Food debris will be cleaned from the burners on the stove. 4. Second floor bathroom tub will be regROUTED. 5. Rust will be removed from second floor bathtub. 6. Tiles will be replaced on third floor bathroom wall. 	<p>4/30/10</p> <p>4/30/10</p> <p>2/28/10</p> <p>4/30/10</p> <p>4/30/10</p> <p>4/30/10</p>
I 103	<p>3504.10(e) HOUSEKEEPING</p> <p>Each GHMRP shall provide clean linens as follows to each resident at least weekly:</p> <p>(e) One (1) wash cloth.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Mentally Retarded Person (GHMRP) failed to provide enough washclothes, for eight of the eight residents included in the sample. (Resident #1, #2, #3, #4, #5, #6, #7, and #8</p> <p>The finding includes:</p> <p>During the environmental inspection on February 26, 2010, beginning at 1:20 p.m. there was only</p>	I 103	<p>Wash cloths was purchased so that Resident will be provided with at least two wash colths.</p>	<p>2/28/10</p>

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I 103	Continued From page 5 eight washcloth in the linen closet.	I 103		
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 the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel, on one of three shifts of drills reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on February 24, 2010, approximately 9:45 a.m., revealed the facility had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. A review of the fire drill reports from March 2009 to February 2010 was conducted on February 24, 2010, at 9:48 a.m. Further review of the fire drill reports from March 2009 to May 2009 and September 2009 to November 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM shift during the week. Interview with the QMRP on the same day at 10:17 a.m., acknowledged that no fire drills were conducted during the 8 AM to 4 PM shift for these periods during the week. At the time of the survey, there was no documented evidence that fire drills were conducted quarterly as required.	I 135	Staff working from 8am to 4pm will receive training on evacuation drills. In the future, QMRP and House Manager will monitor evacuation drills monthly to ensure that drills are held at least quarterly for each shift.	3/31/10

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I 135	Continued From page 6 Also cross-refer to Federal Deficiency Citation W441.	I 135		
I 165	<p>3507.4(c) POLICIES AND PROCEDURES</p> <p>The manual shall incorporate policies and procedures for at least the following:</p> <p>(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident;</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure a policy on destroying medications.</p> <p>The finding includes:</p> <p>Observation of medication administration on February 24, 2010, at 7:55 a.m., revealed that Client #2 refused his medications, given three opportunities by the trained medication employee (TME). At 8:10 a.m., the TME was observed flushing the clients medications down the toilet. Interview with the TME, after the medication was flush, she indicated that the policy was to flush the medication notify the registered nurse and flush the medication down the toilet. Review of the GHMRP policies and procedures manual on February 25, 2010, at approximately 3:30 p.m., revealed no evidence of the aforementioned policy. Interview with the registered nurse on February 26, 2010, at approximately 2:00 p.m., reiterated the TME's procedures of the policy. However, no policy could be located in the manual.</p>	I 165	<div style="border: 1px solid black; padding: 5px;"> <p>The policy for discarding medication will be placed in the facility.</p> </div>	<div style="border: 1px solid black; padding: 5px;"> <p>3/1/10</p> </div>

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
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I 183	Continued From page 7	I 183		
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for eight of the eight residents' in the GHMRP. (Residents #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: 1. Cross refer to W112. The QMRP failed to keep confidential information contained in each client's record. 2. Cross refer to W189. The QMRP failed to ensure staff received effective training while conducting fire drills under various conditions. 3. Cross refer to W240. The QMRP failed to ensure that there were interventions/strategies to address Resident #1's maladaptive behavior (running through the house) in the Behavior Support Plan. 4. Cross refer to W247. The QRMP failed to ensure that clients' were provided opportunities for making choices as a part of their self-management. 5. Cross refer to W249. The QMRP failed to ensure the consistent implementation of resident#1's Behavior Support Plan.	I 183	1. Cross reference W112 2. Cross reference W189 3. Cross reference W193 4. Cross reference W159 #4 5. Cross reference W193	3/22/10 3/31/10 3/31/10 3/31/10 3/31/10

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I 183	Continued From page 8 6. Cross refer to W252. The QMRP failed to ensure the implementation of an effective system of documenting Resident #1's Individual Program Plans. 7. Cross refer to W325. The QMRP failed to ensure nutrition recommendations were addressed. 8. Cross refer to W441. The QMRP to ensure the GHMRP conducted fire drills under varied conditions. 9 Cross refer to W460. The GHMRP QMRP failed to ensure that nutritional training had been effective for staff that prepared Resident #1's meals and snacks.	I 183	6. Cross reference W252 7. Cross reference W325 8. Cross reference W441 9. Cross reference W460	3/31/10 3/31/10 3/31/10 3/31/10
I 206	3509.8 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retardated Persons (GHMRP) failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for one of the twelve staff	I 206		

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1206	Continued From page 9 The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on February 25, 2010, beginning at 1:45 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for one of the twelve staff.	1206		
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, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that residents received comprehensive functional assessments, for one of the four residents in the sample. (Resident#3) The finding includes: Observation of the evening medication administration on February 24, 2010, at 6:50 p.m., revealed Resident#2 received Haldol 5 mg. Interview with the licensed practical nurse (LPN), after during the medication administration indicated that the medication was prescribed for behavior management. Review of the resident's current physician orders dated February 2010, on February 24, 2010, at approximately 11:00 a.m., revealed an order of Paxil CR 12.5 mg, by mouth,	1401	Cross reference W124	3/31/10

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I 401	Continued From page 10 each morning. Interview with the LPN on February 24, 2010, at 6:50 p.m., confirmed that the client received Paxil CR in the morning. Review of Resident#3's physicians orders dated February 2010, on February 25, 2010, at 11:00 a.m., revealed that the aforementioned medications were incorporated in a Behavior Support Plan (BSP) dated June 24,2009. Review of Resident#3's medical evaluation dated June 5, 2009, on February 24, 2010, at 1:50 p.m., revealed that the psychotropic medications were prscribed to address behaviors associated with a diagnosis of psychotic disorder. Further review of the resident's medical record revealed no documented evidence of a psychiatric assessment.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure staff implemented clients' Behavior Support Plans (BSP), for one of the four clients included in the sample (Resident #1) and failed to ensure staff implemented clients feeding program, for one of four clients included in the sample. (Client #1) The findings include: 1. Observations conducted on February 24, 2010, beginning from 10:22 a.m. to 4:00 p.m., revealed staff failed to implement Resident #1's	I 422	Cross reference W193	3/31/10

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I 422	<p>Continued From page 11</p> <p>BSP as follows:</p> <ul style="list-style-type: none"> - At 12:40 p.m., Resident #1 left the dining table and ran toward the administrator's office. Direct Care Staff #1 (DCS) who was providing 1:1 supervision during this time, verbally prompted the Resident to come back to the table. - At 12:50 p.m., Resident #1 left his seat again and ran through the living room area into the administrator's office. He was verbally redirected from a different 1:1 female staff that remained in the dining area. - At 3:18 p.m., Resident #1's housemates was observed to arrive home from day program. - At 3:40 p.m., Resident #1 was observed to pull on Resident #5's shirt. Resident #5 vocalized a loud sound and staff (who was not in close proximity) immediately redirected Resident #1 to let go of his shirt. After the redirecting, Resident #1 was observed to remove his shirt from his body. A minute later, Resident #1 walked over to the dining area, knocked a sponge ball to the floor, and then walked over to the surveyor and grabbed his sweater tightly. Again the staff was not in close proximity to the client. The House Manager intervened by verbally redirecting the Resident 5 times to let go of the surveyor's shirt. - At 3:50 p.m. and 3:55 p.m., Resident #1 was observed taking off his shirt and receiving verbal prompts from a different staff in the area to put his shirt back on. - Continued observations from 4:00 p.m. to 8:35 p.m., revealed Resident #1 received 1:1 supervision indirectly from at least four (4) 	I 422		

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1422	<p>Continued From page 12</p> <p>different staff.</p> <ul style="list-style-type: none"> - At 4:22 p.m., Resident #1 grabbed Resident #4's shirt while engaged in tabletop activities with his peers at the dining table. A Direct Care Staff (DCS) was observed to move a chair between Resident#1 and his peers to prevent him from grabbing other peers. - At 4:30 p.m., Resident #1 walked over to the surveyor and kicked him 2 times on the left lower leg softly before being redirected by DCS. - At 4:37 p.m., Resident #1 walked over to Resident#6 in the living room area and began pulling on his clothes. DCS was observed in the dining area, kitchen, and administrative office. <p>On February 24, 2010, at approximately 10:30 a.m., interview with the Direct Care Staff (DCS) revealed that she was providing 1:1 supervision for Resident #1 along with another DCS to manage maladaptive behaviors (i.e. refusals to get on/off van, any other refusal with staff direct request, self-stimulatory, non-dangerous, running around the house, inappropriate public sexual behaviors, pica, self-injurious behaviors, aggression to others (grabbing/kicking), property destruction, and food refusals).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 25, 2010, at approximately 11:00 a.m., revealed that two female staff were providing 1:1 supervision during the 8 AM to 4 PM shift. Further interview revealed that one of the major duties for the assigned staff working with Resident #1, was to supervise him closely at all times.</p> <p>Review of Resident 1#'s BSP dated October 14, 2009, on February 26, 2010, at 11:45 a.m.,</p>	1422		

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I 422	Continued From page 13 confirmed the DCS and QMRP's interview. Further review of the BSP revealed that when Resident #1 grabs others or grabs their clothes, then staff should intervene. "The sooner, the better as Resident #1 tends to escalate, make a tighter and tighter grip." The BSP also stated to verbally redirect the Resident to do something else with his hands. There was no evidence that on February 24, 2010, that the GHMRP staff demonstrated competency in the implementation of the resident's BSP.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Person (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for six of the six residents of the GHMRP. (Residents #1, #2, #3, #4 and #6) and the GHMRP failed to keep confidential information contained in each resident's record, for eight of the eight residents residing in the GHMRP. (Residents #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: 1. The GHMRP failed to ensure that informed	I 500		
			1. Cross reference W124	3/31/10

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1500	<p>Continued From page 14</p> <p>consent was obtained from Resident #3's guardian prior to the administration of his psychotropic medications.</p> <p>During the entrance conference on February 24, 2010, beginning at 9:30 a.m., the Qualified Mental Retardation Professional (QMRP) indicated that Resident #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the Resident did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Review of the Resident's current physician orders dated February 2010, on February 24, 2010, at approximately 11:00 a.m., revealed an order of Paxil CR 12.5 mg, by mouth, each morning. Interview with the Licensed Practical Nurse (LPN) on February 24, 2010, at 6:50 p.m., confirmed that the Resident received Paxil CR in the morning.</p> <p>The QMRP's statement was verified on February 25, 2010, at approximately 1:00 p.m., through review of Resident #3's psychological assessment dated June 24, 2009. According to the assessment, Resident #3 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the Resident had a court appointed guardian who is involved in his habilitation planning and decision making process.</p> <p>Record verification on February 25, 2010, at 1:45 p.m., revealed that Resident #3's guardian had given informed consent for the use of Haldol 5 mg QPM dated April 7, 2009. There was no</p>	1500		

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I 500	Continued From page 15 consent signed, however, for the Resident's current Paxil CR 12.5 mg, by mouth, in the morning. At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the Resident and/or legally authorized representative prior to the administration of the psychotropic medication. 2. On February 24, 25, and 27, 2010, a chart was observed posted openly on the bulletin board located in the kitchen. Review of the chart revealed that it included each resident's full name and a listing of their prescribed diet. For example, Resident #3 was prescribed a regular calorie, mechanical soft double portion diet. The other residents also had specially prescribed diets. This practice failed to ensure the confidentiality of the resident's personal information. On February 26, 2010, at 12:15 p.m., the House Manager acknowledged that the chart posted in the kitchen contained confidential dietary information.	I 500	2. Cross reference W112	3/22/10