

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS	STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011
---	---

(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>INITIAL COMMENTS</p> <p>A licensure survey was conducted on June 8, 2011 through June 10, 2011. A random sample of three residents was selected from a resident population of three men and three women with various degrees of disability. One of the six residents was reported to have been transported to a local emergency room on June 7, 2011 at 10:20 p.m., and to have expired while in the emergency room. As a result of this information, an investigation was conducted with the licensure survey.</p> <p>The survey findings was based on observations in the home, interviews with administrative management, nursing and direct care staff, and the review of resident and administrative records, including incident reports.</p>	1 000	<p><i>Received 7/8/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
1 043	<p>3502.2(c) MEAL SERVICE / DINING AREAS</p> <p>Modified diets shall be as follows:</p> <p>(c) Reviewed at least quarterly by a dietitian.</p> <p>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 that the resident's modified diets were reviewed at least quarterly by a dietitian for one of the three residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Observation on June 8, 2011, at approximately 12:25 p.m. revealed a direct care staff feeding Resident #2 a pureed lunch. The staff identified the meal as macaroni and cheese, carrots and</p>	1 043	<p>Peabody Responses July 2011</p> <p>3502.2 (c)</p> <p>The nutritionist had visited the home to review the status of Resident #2 and others on 4-4-11. At that time she determined that no salt should be added to Resident #2's diet. As pointed out by the surveyor, the nutritionist failed to submit written documentation of her findings and recommendations to the QIDP in a timely manner, despite repeated requests by the QIDP. The quarterly was obtained during the survey and is now in the record...7-6-11 The physician's orders have been modified to reflect no added salt...7-6-11</p> <p>In the future, the QIDP will inform the Director of Residential Services when a clinical professional fails to provide a needed service or documentation of that service in a timely manner. The Director will take appropriate action to insure follow up by the clinical professional...7-6-11</p> <p>The QIDP will track all such recommendations via monthly review of the individual records and follow up in a proactive manner to insure all recommendations are implemented in a timely manner...7-6-11</p>	

Health Regulation & Licensing Administration

Letitia M. Moore Director of Residential Services TITLE _____

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

(X6) DATE: *7/8/11*

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011	
(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
1043	<p>Continued From page 1</p> <p>celery with salad dressing.</p> <p>Record review on June 9, 2011, at approximately 3:10 p.m. revealed the most recent nutrition assessment dated August 7, 2010. The resident had a dietary order for high fiber, and add salt to meals. Interview with the direct care staff on the same day at 3:16 p.m. revealed that she adds salt to Resident #2's food as recommended. The assessment also recommended that an investigation be conducted to determine the need to add salt to the resident's meals. It should be noted the resident's diagnosis included hypertension and he was prescribed Metoprolol.</p> <p>Interview with the administrative staff revealed that the nutritionist had been in the facility since August of 2010, however, at the time of the survey, there was no documented evidence of any nutritional investigation or quarterly reviews since August 2010.</p>	1043	
1090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, the group home for persons with intellectual disabilities (GHPID) failed to ensure the maintenance and upkeep of the facility's environment as required by this section.</p> <p>The finding includes:</p>	1090	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011	
(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
1090	Continued From page 2 The facility failed to ensure that the hand railing on the ramps leading from the resident's room were free of rust. One of two lounge chairs in the living room had torn cushions. The upper kitchen cabinet door was off and on the floor under the counter. In the dining room four chair cushions were observed to be soiled and one of the cushions was torn. The GHPID failed to ensure an effective system of monitoring and maintenance of their physical environment.	1090	3504.1 <ul style="list-style-type: none"> • Hand railing – will be scrapped and repainted by...7-30-11 • Lounge Chair – will be replaced by...7-30-11 • Kitchen Cabinet Door – has been repaired...6-10-11 • Dining Room Chairs – seat cushions will be replaced by...7-30-11 The chair cushions have been washed to address the stains...6-20-11 The Job Description of the Assistant to the Director of Residential Services has been modified to place greater emphasis on environmental audits and environmental upkeep. Tracking of environmental issues and proactive coordination of follow up will become essential elements of this position as of...8-1-11
1206	3509.6 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 Persons with Intellectual Disabilities (GHPID) failed to ensure that each employee, prior to employment and annually thereafter, provided a physician's certification that a health inventory had been performed and that the employee's health status allowed him or her to perform the required duties, for one (1) of nineteen house staff and for seven of nine consultants contracted to provide services (social worker, nutritionist, psychologist, pharmacist, speech & language, primary care physician and the physical therapist.)	1206	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PEABODY STREET NE WASHINGTON, DC 20011		
(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 206	Continued From page 3 The finding includes: On June 8, 2011, during a review of the facility personnel records at approximately 1:30 p.m. one direct care staff [Staff #5] and seven professional consultants (social worker, nutritionist, psychologist, pharmacist, speech & language, primary care physician and the physical therapist) failed to have evidence of a current health certificate on file. Interview with the facility's registered nurse (RN) on the same date at approximately 3:00 p.m. revealed that the human resources department would be contacted to obtain current records for the aforementioned individuals. At the time of the survey, however, the current health certificates were not presented for review.	I 206	3509.6 The needed, current health certificates will be obtained by...7-30-11 MTS HR will track compliance on a routine, ongoing basis based on monthly audits and will proactively notify staff and consultants on the need to update required information. Failure to do so will result in appropriate follow up actions...7-30-11		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) 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) for one of three residents included in the sample. (Resident #1) The findings include:	I 500			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION. A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011		
(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)	
1500	<p>Continued From page 4</p> <p>Section 7-1305.05 (g). [Formerly 6-1965] Each customer shall have the right to prompt and adequate medical attention for any physical ailments and shall receive a complete physical examination upon admission and at least once a year thereafter.</p> <p>The facility failed to ensure the resident's right to receive prompt medical attention, as evidenced below:</p> <p>a. A licensure survey was conducted on June 8, 2011 through June 10, 2011. Upon entrance of the GHPID, interview with the Licensed Practical Nurse (LPN #1) at approximately 8:50 a.m. revealed there was a population of six residents. Further interview with LPN #1 revealed one of the six residents had been transported to the emergency room on June 7, 2011 at approximately 10:20 p.m. According to LPN #1, the resident was reported to have expired on June 7, 2011 while he was in the emergency room.</p> <p>Beginning at approximately 9:52 a.m. on June 8, 2011, an interview was conducted with LPN #2, that was on duty on the evening of June 7, 2011. According to LPN #2, the direct care staff reported that on June 7, 2011, the resident only ate approximately 25% of his dinner. Further interview with the LPN revealed she observed Resident #1 sweating and his shirt was wet. The nurse also said he looked uncomfortable and appeared to be restless. The LPN stated that she instructed the staff to first complete Resident #1's p.m. care and then she would assess him.</p> <p>At approximately 8:20 p.m., LPN #2 said she was requested to come to the resident's bedroom. Resident #1 was no longer sweating because the</p>	1500		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011		
(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
1500	<p>Continued From page 5</p> <p>staff had bathed him. The LPN revealed at that time she checked the resident's blood pressure and it was 120/92. She then contacted the GHPID's Registered Nurse (RN) to report the resident's condition at 9:20 p.m. She stated that the RN asked her if she had done the resident's vital signs. According to LPN #2, she replied "no", and indicated that she was "going to do them now." Further discussion with LPN #2 revealed that the resident's respiration was 28, which she described as being high. After checking the resident's vitals, she called the RN back to report the results. According to LPN #2, the RN indicated that the resident "needs to go to the emergency room and instructed her to call the resident's primary care physician (PCP)."</p> <p>According to the LPN #2, she attempted to reach the PCP, but was unsuccessful, therefore she left a message. She further conveyed that she waited to hear from the PCP before sending the resident to the hospital because she first wanted to get instructions from the PCP. At 9:55 p.m., the PCP returned her call and instructed LPN #2 to send the resident to the emergency room for further evaluation. LPN #2 revealed that she contacted the GHPID's driver to transport the resident to the emergency room.</p> <p>Continued interview with LPN #2, revealed the driver arrived between 10:15 p.m. and 10:20 p.m. (greater than two hours after Resident #1 displayed symptoms of distress) to escort the resident to the emergency room. The LPN said she did not accompany the resident to the emergency room, but instructed the Certified Nursing Assistant (CNA #1) to accompany him. Uncertain of the time, the LPN reported that she received a call from the CNA informing her that the hospital staff was trying to resuscitate</p>	1500		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011	
(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 500	<p>Continued From page 6</p> <p>Resident #1. Approximately forty to forty-five minutes later, the nurse (LPN #2) reported she received another call from the hospital to informed her that Resident #1 had expired.</p> <p>When questioned regarding the GHPID's policy on emergencies, the LPN revealed that they are instructed to call 911 for all emergencies. She was asked why she did not call 911. She stated because the resident did not "look bad."</p> <p>b. Interview with CNA #1 on June 8, 2011, at approximately 3:25 p.m. revealed dinner was served between 6:30 p.m. and 7:00 p.m. She further disclosed that at 8:20 p.m., Resident #1 was provided p.m. care in accordance with LPN #2's instructions. Continued discussion with CNA #1 verified that LPN #2 took the resident's blood pressure after his bed bath.</p> <p>c. Interview with CNA #2 on June 8, 2011 at approximately 4:02 p.m. revealed he observed Resident #1 before providing his p.m. care. According to CNA #2, the resident was sweating and breathing fast. CNA #2 reported that he informed LPN #2 of the residents condition and requested her come to his bedroom. After LPN #2 observed the client, he indicated that he was instructed by the LPN #2 to complete Resident #1's p.m. care before she assessed the resident.</p> <p>d. Additional interview with LPN #2 and a review of Resident #1's medical record on June 8, 2011, at approximately 4:33 p.m. revealed the resident had been seen by his PCP on June 2, 2011. According to further interview and record review, Resident #1 was diagnosed with an Upper Respiratory Infection (URI) on the date of the PCP visit. Continued interview with LPN #2 revealed the resident stayed home from his day</p>	I 500	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2011
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS		STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011	
(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
1500	Continued From page 7 program from June 3, 2011 through June 6, 2011. It should be noted that additional record review on June 8, 2011, revealed Resident #1 had a history of recurrent URI and was previously diagnosed with an URI on February 24, 2011. At the time of the survey, the GHPID failed to ensure adequate and prompt medical (emergency) attention was provided for Resident #1.	1500	3523.1 The nurse in question is currently out on leave pending the outcome of the internal investigation and an external mortality review. There will be appropriate action taken based on the findings and recommendations of the internal investigation... 7-6-11 All other nursing personnel and staff in the home will be retrained to insure that all understand that 911 is called immediately in such situations... 7-8-11

PRINTED: 07/01/2011
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SVCS	STREET ADDRESS, CITY, STATE, ZIP CODE 39 PEABODY STREET NE WASHINGTON, DC 20011
--	---

(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)	CORRECTION SHOULD BE THE APPROPRIATE DATE (X5) COMPLETE DATE
--------------------	--	---------------	---	---

R 124 4701.4 BACKGROUND CHECK REQUIREMENT R 124

The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency.

This Statute is not met as evidenced by: Based on interview and review of the records the GHMRP failed to ensure all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency.

The finding includes:

Review of personnel records on June 8, 2011, beginning at approximately 2:30 p.m. revealed that Staff #18 did not have evidence of a background check.

At the time of the survey, there was no evidence that a background check had been obtained for this staff member.

4701.4

The needed, current background check will be obtained by 07-10-11
MTS HR will track compliance on a routine, ongoing basis based on monthly audits and will proactively conduct a background check on new hires.....08-30-11

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

STATE FORM

6894

FE5A11

Continuation sheet 1 of 1