

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

PRINTED: 05/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G190	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2011
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 EVARTS ST, NE WASHINGTON, DC 20018
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

A recertification survey was conducted from May 10, 2011 through May 11, 2011. A sample of two clients was selected from a population of four men with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.

The findings of the survey were based on observations and interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.

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 interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients included in the sample. (Client #1)

The finding includes:

The facility failed to provide evidence that informed consent was obtained from Client #1

W 000

*Received 5/26/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
890 North Capitol St., N.E.  
Washington, D.C. 20002

W 124

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Constance A. Reese Program Director</i>	TITLE	(X6) DATE 5/27/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 and/or his legal guardian for sedation's given during medical appointments, as evidenced below:  During the entrance conference on May 10, 2011, at 10:01 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that Client #1 had a legal guardian that operated as the clients designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of his medications.  On May 11, 2011, at 9:40 p.m., review of Client #1's medical book revealed a written physician order dated December 17, 2010, that documented that Client #1 was to receive Ativan 3 mg by mouth one hour prior to an ultra sound of his breast and blood work appointment on December 27, 2010. Further record review revealed a second written order dated October 25, 2010, that also documented that the client was to receive Ativan 2 mg by mouth thirty (30) minutes prior to lab work on November 9, 2010.  Interview with the QIDP and review of the medication administration records on May 11, 2011, at 9:57 p.m., confirmed that Client #1 did receive the aforementioned sedation's as ordered. Further interview with the QIDP revealed that she was unsure if the consents for the use of Ativan had been obtained prior to administering the medications.  On May 11, 2011, at 11:56 p.m., review of Client #1's psychological assessment dated September 9, 2010, confirmed that the client lacked the capacity to grant, refuse, or withdraw consent to	W 124	The QIDP and Residential Manager will meet with Client #1's medical guardian as well as Client #1 to review all new and recommended treatments to include Client #1's individual rights to refuse treatment. QIDP and Residential Manager will obtain required consent forms from the guardian prior to appointment dates for sedation administration. QIDP and Residential Manager will obtain a signed consent form and will submit to the Human Rights Committee for review. The DON will review and update the procedures for obtaining consent forms for sedation and psychotropic medications.	6/10/11

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W 124 Continued From page 2  
any ongoing medical treatment. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to him and/or his legally authorized representative for the use of the aforementioned sedation's.

W 124

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

Cross reference W249

6/10/11

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was monitored by the qualified intellectual disabilities professional (QIDP), for one of two clients in the sample. (Client #1)

The findings include:

1. Cross refer W193. The facility's QIDP failed to ensure 1:1 staff demonstrated competency in implementing Client #1's behavior support plan.

2. Cross refer to W249. The facility's QIDP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations.

W 193 483.430(e)(3) STAFF TRAINING PROGRAM

W 193

Cross reference W193

6/10/11

Staff must be able to demonstrate the skills and techniques necessary to administer interventions

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W 193	<p>Continued From page 3 to manage the inappropriate behavior of clients.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate competency in the implementation of a client's Behavior Support Plan (BSP), for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Cross refer to W249. The facility failed to ensure that 1:1 staff demonstrated competency in implementing Client #1's Behavior Support Plan (BSP).</p>	W 193	Cross reference W249	6/10/11
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure a client's behavior support plan (BSP) was implemented consistently, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p>	W 249	The QIDP and Residential Manager will schedule a training with the psychologist to train all staff on Client #1's BSP and one to one protocol.	6/10/11

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<p><b>W 249</b> Continued From page 4</p> <p>The facility failed to ensure that Client #1's 1:1 staff remained in close proximity as indicated in his in accordance with his BSP, as evidence below:</p> <p>On May 10, 2011, at 9:30 a.m., Client #1 was observed to walk over to the surveyor to shake my hand while his 1:1 staff remained on the other side of the dining table. At 9:33 a.m., Client #1 walked over to the surveyor to shake my hand for a second time while his 1:1 staff remained on the other side of the dining table. This occurred again at 9:40 a.m. At 9:46 a.m., the 1:1 staff was observed on the house phone while Client #1 walked over to shake the surveyor's hand. Later that day at 4:43 p.m., Client #1's 1:1 staff was observed approximately seven to ten yards away from him while in the backyard with other staff and his housemates. At 4:53 p.m., Client #1 was observed looking inside the outside trash can while his 1:1 staff remained approximately ten to twelve yards away from him.</p> <p>Interview with the 1:1 staff on May 11, 2011, at approximately 4:40 p.m., revealed that Client #1 received 1:1 staffing 16 hours a day to manage physical safety maladaptive behaviors. (i.e. pica, non-compliance, inappropriate public sexual behaviors, self-injurious behaviors, property destruction, and aggression to others). Further interview with Client #1's 1:1 staff confirmed that he did not remain within arms length at all times as observed on May 10, 2010.</p> <p>Review of Client #1's behavior support plan (BSP) dated September 29, 2010, on May 11, 2011, at 12:01 p.m., confirmed the 1:1 staff's</p>	<b>W 249</b>		

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W 249	<p>Continued From page 5</p> <p>interview of the aforementioned maladaptive behaviors. Further review of Client #1's BSP revealed the 1:1 staff must remain within arms reach of Client #1 at all times (i.e., home, community, day, and while being transported). The BSP also added that Client #1's 1:1 staffing was in place for safety precautions relative to ingesting items that are potentially dangerous and to ensure the safety of others when he attempts to be physically aggressive.</p> <p>At the time of the survey, there was no evidence that Client #1's 1:1 staff implemented his BSP as recommended.</p> <p>Note: It should be noted that in an interview with Client #1's 1:1 staff during the second shift (8:00 a.m. to 4:00 p.m.) on May 10, 2011, at 11:56 p.m., it was acknowledged that he did not remain within arms length of Client #1 as indicated in the BSP.</p>	W 249		
W 382	<p>483.460(1)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep all drugs locked securely when not being prepared for administration, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On May 10, at 4:28 p.m., the trained medication</p>	W 382		

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W 382	Continued From page 6 employee (TME) was observed to retrieve Client #1's medications from the medication file cabinet. Approximately three minutes later, the TME was observed in the kitchen trying to get Client #1 to return back to the dining table to take his prescribed medications. During this time, the medication file cabinet was observed to be unlocked. Several staff and clients were observed walking near the file cabinet. At 4:31 p.m., the TME placed the lock back on the medication file cabinet.  Interview with the registered nurse (RN) on May 11, 2011, at approximately 1:30 p.m., revealed that the medication file cabinet was required to be locked at all times when medications were not being prepared. Later that day at 4:37 p.m., interview with the TME acknowledged that he had left the medication cabinet unattended unlocked.	W 382	Trained medication employee will receive additional training from the DON on medication administration procedures and protocols.	6/3/11
W 441	463.470(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:  On May 10, 2011, at 12:13 p.m., review of the facility's fire drill records revealed that most of the fire drills were conducted utilizing the front, back, and side door exits. Interview with the qualified	W 441	QIDP and Residential Manager will train staff on fire drill procedures and utilizing all points of egress.	6/3/11

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W 441	Continued From page 7 intellectual disabilities (QIDP) on May 10, 2011, at approximately 2:15 p.m., revealed that the facility had at least four methods of egress (front door, back door, side door, and basement door). Further review of the fire drill records revealed that the basement door exit had not been used. This was acknowledged through interview with the QIDP on the same day at approximately 2:45 p.m. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441			

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1 000 INITIAL COMMENTS

A licensure survey was conducted from May 10, 2011, through May 11, 2011. A sample of two residents was selected from a population of four males with varying degrees of intellectual disabilities.

The findings of the survey were based on observations, interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.

1 000

1 091 3504.2 HOUSEKEEPING

Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used.

This Statute is not met as evidenced by: Based on observations and interview, the group home for persons with intellectual disabilities (GHPID) failed to maintain the interior and exterior of the GHPID in a safe, clean, orderly, attractive, and sanitary manner for four of four residents residing in the facility. (Residents #1, #2, #3, and #4)

1 091

The findings include:

Observation and interview with the qualified intellectual disabilities professional (QIDP) during the environmental walk through on May 11, 2011, beginning at 3:48 p.m., acknowledged the following:

1. The toilet seat located on the second level was

1. The toilet seat was tightened. The QIDP and Residential Manager will conduct weekly inspections of the facility to include checks of the bathroom fixtures to ensure safety.

5/23/11

Health Regulation & Licensing Administration  
*Caroline L. Reese* Program Director  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

5/26/11

Health Regulation & Licensing Administration

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I 091	Continued From page 1 observed to be loose.  2. Client #2's right closet door was observed with several cracks.  3. The ceiling tiles located in the bathroom on the first level were observed with water stains.  4. There was a light out and a missing light fixture observed on the ceiling fan located above the dining table.  5. The vent cover underneath the stove was observed with grease build up.	I 091	2. Client #2's right closet door will be replaced and checked weekly for damage.  3. Ceiling tiles in the first floor bathroom were changed and a leak inspection will be conducted and monitored.  4. The light fixture in the dining room will be replaced.  5. The vent cover will be cleaned with degreaser and will be cleaned once a week.	6/10/11  6/10/11  6/10/11  6/10/11
I 180	<b>3508.1 ADMINISTRATIVE SUPPORT</b>  Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.  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 each resident's active treatment program was monitored by the qualified intellectual disabilities professional (QIDP), for one of two residents in the sample. (Resident #1)  The findings include:  1. Cross refer W193. The GHPID's QIPD failed to ensure 1:1 staff demonstrated competency in implementing Resident #1's behavior support plan.  2. Cross refer to W249. The GHPID's QIPD failed to ensure continuous active treatment was	I 180		

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I 180	Continued From page 2  Implemented in accordance with the interdisciplinary team (IDT) recommendations.	I 180	Cross reference W249	6/10/11
I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  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 have on file for review, current training in cardiopulmonary resuscitation (CPR) and first aid, for one of two licensed practical nurses (LPN #1).  The finding includes:  The GHPID failed to ensure a current CPR and First Aid certification was on file for LPN #1. This was acknowledged through interview with the qualified intellectual disabilities professional on May 11, 2011, at approximately 3:15 p.m.	I 227	The QIDP and Residential Manager will obtain CPR/ First Aid certification copies for LPN #1 and will conduct monthly personnel audits to ensure compliance with credentials.	5/27/11
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, interview, and record review, the facility staff failed to ensure a client's	I 422	Cross reference W249	6/10/11

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I 422	<p>Continued From page 3</p> <p>behavior support plan (BSP) was implemented consistently, for one of the two residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that Resident #1's 1:1 staff remained in close proximity as indicated in his in accordance with his BSP, as evidence below.</p> <p>On May 10, 2011, at 9:30 a.m., Resident #1 was observed to walk over to the surveyor to shake my hand while his 1:1 staff remained on the other side of the dining table. At 9:33 a.m., Resident #1 walked over to the surveyor to shake my hand for a second time while his 1:1 staff remained on the other side of the dining table. This occurred again at 9:40 a.m. At 9:46 a.m., the 1:1 staff was observed on the house phone while Resident #1 walked over to shake the surveyor's hand. Later that day at 4:43 p.m., Resident #1's 1:1 staff was observed approximately seven to ten yards away from him while in the backyard with other staff and his housemates. At 4:53 p.m., Resident #1 was observed looking inside the outside trash can while his 1:1 staff remained approximately ten to twelve yards away from him.</p> <p>Interview with the 1:1 staff on May 11, 2011, at approximately 4:40 p.m., revealed that Resident #1 received 1:1 staffing 18 hours a day to manage physical safety maladaptive behaviors. (i.e. pica, non-compliance, inappropriate public sexual behaviors, self-injurious behaviors, property destruction, and aggression to others). Further interview with Resident #1's 1:1 staff confirmed that he did not remain within arms length at all times as observed on May 10, 2010.</p>	I 422		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/11/2011
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 EVARTS ST, NE WASHINGTON, DC 20018		
(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 422	Continued From page 4  Review of Resident #1's behavior support plan (BSP) dated September 29, 2010, on May 11, 2011, at 12:01 p.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Resident #1's BSP revealed the 1:1 staff must remain within arms reach of Resident #1 at all times (i.e., home, community, day, and while being transported). The BSP also added that Resident #1's 1:1 staffing was in place for safety precautions relative to ingesting items that are potentially dangerous and to ensure the safety of others when he attempts to be physically aggressive.  At the time of the survey, there was no evidence that Resident #1's 1:1 staff implemented his BSP as recommended.  Note: It should be noted that in an interview with Resident #1's 1:1 staff during the second shift (8:00 a.m. to 4:00 p.m.) on May 10, 2011, at 11:58 p.m., it was acknowledged that he did not remain within arms length of Resident #1 as indicated in the 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 interview and record review, the facility failed to ensure the rights of each resident and/or their legal guardian to be informed of the resident's medical condition, developmental and	I 500			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0200</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/11/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1008 EVARTS ST, NE WASHINGTON, DC 20018</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
I 500	Continued From page 6  Ativan had been obtained prior to administering the medications.  On May 11, 2011, at 11:56 p.m., review of Resident #1's psychological assessment dated September 9, 2010, confirmed that the resident lacked the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment. At the time of the survey, the facility failed to provide evidence that resident #1's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to him and/or his legally authorized representative for the use of the aforementioned sedation's.	I 500	