

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

PRINTED: 02/18/2010
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
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W 000	INITIAL COMMENTS A recertification survey was conducted from 1/13/2010 through 1/21/2010. The survey was initiated utilizing the fundamental survey process. However, due to information obtained from the unusual incident reports and the nursing notes on 1/14/2010, the survey was extended under the Conditions of Participation in Client Protections, Health Care Services and Client Behaviors and Facility Practices. A random sampling of two clients was selected from a residential population of four females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the client and administrative records, including the incident reports. Based on the findings, the facility failed to meet the compliance requirements with the Conditions of Participation in Client Protections.	W 000	<p><i>Received 2/24/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 225 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to exercise general policy and operational direction over the facility in the following areas for one of three clients in the sample. [Client #2] The findings include:	W 104		<p>Cross reference W122</p> <p>3/2/10</p>

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

Constantine A. Rees Program Director TITLE DATE 2/24/10

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 104	Continued From page 1 1. The governing body failed to ensure effective procedures were implemented to prevent conditions of neglect with regards to client's health and safety. [Cross reference W149] 2. The governing body failed to ensure the implementation of an effective system of reporting and investigating injuries of unknown origin. [W153 and W154]	W 104	Primary Care Physicians will review all incidents for Client #1 and complete a summary of his findings. CMS Nursing Director will send a letter to the day program requesting direct communication of all health concerns for all individuals. In the future, Client #1's primary care physician will be notified of all injury/ falls in a timely manner. The QMRP will ensure all incidents including those of unknown origin are reported in a timely manner and followed up by the primary care physician for all individuals. In addition all staff will be trained on reporting incidents and fall protocols for all individuals.	3/2/10
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to effectively implement procedures that prohibited the potential mistreatment, neglect or abuse of the client [Cross reference W149]; failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to other officials according to District of Columbia Regulations 22 DCMR, Chapter 35, Section 3519.10 [Cross reference W153]; failed to investigate all incidents of unknown origin [Cross reference W154]; failed to ensure staff demonstrated competency in implementing Client #1's Behavior Support Plan [Cross reference W163]; failed to ensure that a client received prompt medical care to address recurrent falls and injuries of unknown origin [Cross reference W322]; and failed to ensure that a client received adequate nursing services to address recurrent falls and injuries of unknown origin [Cross reference W331].	W 122		

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W 122 W 149	<p>Continued From page 2</p> <p>The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to implement an effective procedure to monitor and coordinate services to prevent conditions of potential abuse, neglect and/or mistreatment to ensure the health and safety of two of two sampled clients. [Clients #1 and #2]</p> <p>The findings include:</p> <p>The facility failed to implement an effective procedure to monitor any patterns of repeated falls and injuries of unknown origin to ensure clients are free from abuse and neglect as evidenced below.</p> <p>1. Review of the unusual incident reports on 1/12/2010 at 10:24 a.m. and a review of Client #1's daily nursing notes on 1/19/2010 at approximately 10:00 a.m. revealed Clients #1 and #2 sustained falls and several injuries of unknown origin.</p> <p>A synopsis of the falls and injuries found on record is outlined below:</p> <p>Evidence of Falls</p>	W 122 W 149	<p>Gross reference W122</p> <p>The QMRP and the Primary Nurse will meet once a week to review medical progress notes and to address any medical concerns. In addition a medical log book will be used to ensure communication between the nurse and the QMRP.</p>	3/2/10 3/2/10

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W 149	Continued From page 3 a. 10/27/2009 Incident Report: Staff was assisting Client #1 to the restroom while out on a doctor's appointment. She refused to stand and flopped onto the toilet seat from the wheelchair and she became 'wedged' in the toilet seat. She sustained a bruise on her right leg. b. 7/1/09 - Nursing note: Staff stated Client #1 fell on her left side in the dining room; assessed by the nurse and was found to show no signs of injury/pain; scalp abrasion appeared clear/dry. c. 8/28/2009 Incident Report: Client #1 was being transported from home to van by staff; staff slipped causing Client #1 and wheelchair to fall backwards. Client #1 sustained lacerations on her back and was sent to ER for further assessment". Evidence of Injuries of Unknown Origin a. 7/20/2009 Incident Report: Unknown bruises found on Client #1's lower back and right inner arm. Client was assessed by LPN and no treatment was needed. b. 6/23/2009 Incident Report: Staff on the 12-8 a.m. shift noticed Client #1 was bleeding from a scratch on her forehead. c. 7/3/09 - Nursing Note: pain, discomfort, weakness and shaking of Client #1's left leg; purple skin coloration like a bruise mark on right breast approximately 2.5 x 2cm. d. 7/3/09 - Nursing Note: Client #1 sleeping all day except meals; RN on call advised [evening medication nurse] to hold Zyprexa in PM; Client #1 was sedated for a medical appointment the	W 149	a. Cross reference W122 b. Cross reference W122 c. Cross reference W122 a. Cross reference W122 b. Cross reference W122 c. Cross reference W122 d. Cross reference W122	3/2/10 3/2/10 3/2/10 3/2/10 3/2/10 3/2/10

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W 149	Continued From page 4 day before. a. 7/20/09 - Day Program Nursing Note: bruise on right arm near Client #1's elbow, approximately 3 cm by 2 cm in diameter, red and black in color. f. 7/24/09 - Day Program Nursing Note: Client #1 complained of back pains and was assessed to have two large bruises on the lower part of her back. The bruise on the left side measured 2 inches and the right side bruise measured 3 inches in width. The bruises were purple, yellow and green in color. g. 7/25/09 - Nursing Note: purple coloration on Client #1's right hand / upper arm. Two [2] purple colorations above buttocks. h. 8/3/09 - Day Program Nursing Note: Client #1 complained of back pains and bruise to right upper posterior of forearm. i. 8/18/09 - Day Program Nursing Note: Client #1 presents with a scratch the size of a pencil eraser to right forearm. j. 8/28/09 - Nursing Note: Client #1 taken to Emergency Room [ER] for an injury which occurred in the morning [AM]; prominent abrasion to right scapula, upper mid back and neck. k. 9/9/09 - Day Program Nursing Note: Bruise on Client #1's right arm; staff noticed it when she took her sweater off. l. 9/26/09 - Nursing Note: large bruise above buttocks in center of Client #1's back and dime sized old bruise on left buttocks.	W 149	e. Cross reference W122 f. Cross reference W122 g. Cross reference W122 h. Cross reference W122 i. Cross reference W122 j. Cross reference W122 k. Cross reference W122 l. Cross reference W122	3/2/10 3/2/10 3/2/10 3/2/10 3/2/10 3/2/10

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W 149	Continued From page 5 m. 10/18/2009 - a form titled "Staff Statement" documented a bruise on the right side of Client #2 's hip was found while staff was giving her a shower. n. 10/19/2009 - Incident Report: Bruises were discovered on Client #2's right leg/thigh and on her right foot/toes. The corresponding Emergency Room [ER] discharge summary dated the same day identified " , possible toe fracture " . o. 10/21/09 - Nursing Note: bruise on Client #1's upper right thigh; refused and also had difficulty in standing. There was no documented evidence on file at the time of survey to reflect the nursing staff ensured the pattern of repeated injuries of unknown origin were properly assessed to rule out neglect or abuse. In addition, there was also no documented evidence that the primary care physician was notified of these injuries of unknown origin. Interview with the facility's registered nurse [RN] and qualified mental retardation professional [QMRP] on 1/13/2010, at approximately 10:30 a.m. revealed the facility did not have a procedure in place to effectively monitor any patterns of repeated falls and repeated occurrences of injuries of unknown origin. Further interview with the facility's Administrator, director of nursing [DDN], qualified mental retardation professional [QMRP], and the residential director [RD] on 1/21/2010, at approximately 11:10 a.m. revealed incident	W 149	m. Cross reference W122 n. Cross reference W122 o. Cross reference W122	3/2/10 3/2/10 3/2/10

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W 149	Continued From page 6 reports should have been generated for each of the nursing notes that reflected Client #1 sustained an injury of unknown origin. In addition, this interview verified the facility did not have an effective system of monitoring in place to address the recurring injuries of unknown origin for both clients. 2. Interview with the qualified mental retardation professional (QMRP) on 1/14/2010 at approximately 9:40 a.m. revealed Client #1 tends to flop when being taken to the restroom and when being transferred to and from her bed. Record review revealed she sustained an injury to her leg on 10/27/2009 and also sustained several injuries of unknown origin around her hips and buttocks as documented from the nursing notes above. There was no documented evidence an effective procedure was implemented in a timely fashion by the nursing staff to address Client #1's flopping and the potential injuries that may have occurred from that behavior.	W 149	2. A raised toilet seat with arms and bars have been installed in the restroom to assist Client #1 when using the restroom. Staff will receive additional training in transferring and assisting Client #1.	3/2/10	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure incident reports were generated for all unusual incidents including	W 153			

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W 153	<p>Continued From page 7</p> <p>Injuries of unknown origin and reported immediately to the administrator and other officials according to District of Columbia Regulations [22 DCMR, Chapter 35, Section 3519.10] for one of four clients in the sample. [Client #1]</p> <p>The findings include:</p> <p>Review of Client #1 's daily nursing notes on 1/19/2010 at approximately 10:00 a.m. revealed several notations of injuries of unknown origin were documented in 2009. A synopsis of the nursing entries is presented below:</p> <ol style="list-style-type: none"> 7/1/09 - Staff stated Client #1 fell on her left side in the dining room; assessed by the nurse and was found to show no signs of injury/pain; scalp abrasion appeared clean/dry. 7/3/09 - Nursing Note - pain, discomfort, weakness and shaking of left leg. Purple skin coloration on right breast approximately 2.5 x 2cm. 7/20/09 - Day Program Nursing Note - bruise on right arm near her elbow, approximately 3 cm by 2 cm in diameter; red and black in color. 7/24/09 - Day Program Nursing Note - Client #1 complained of back pains and was assessed to have two large bruises on the lower part of her back. The bruise on the left side measured 2 inches and the right side bruise measured 3 inches in width. The bruises were purple, yellow and green in color. 7/25/09 - Nursing Note - purple coloration on right hand / upper arm. Two [2] purple 	W 153	<p>1. Cross reference W122</p> <p>2. Cross reference W122</p> <p>3. Cross reference W122</p> <p>4. Cross reference W122</p> <p>5. Cross reference W122</p>	<p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p>

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W 153	<p>Continued From page 8 colorations above buttocks.</p> <p>6. 8/3/09 - Day Program Nursing Note - Complained of back pains and bruise to right upper posterior of forearm.</p> <p>7. 8/18/09 - Day Program Nursing Note - presents with a scratch the size of a pencil eraser to right forearm.</p> <p>8. 8/28/09 - Nursing Note - Emergency Room [ER] visit for an injury which occurred in the morning [AM]; prominent abrasion to right scapula, upper mid back and neck.</p> <p>9. 9/1/09 -Nursing Note - right of back and upper scapula abrasions resolved.</p> <p>10. 9/9/09 - Day Program Nursing Note - Bruise on right arm; staff noticed it when she took her sweater off.</p> <p>11. 9/26/09 - Nursing Note - large bruise above buttocks in center of back and dime sized old bruise on left buttocks.</p> <p>12. 10/21/09 - Nursing Note - bruise on upper right thigh; refused and also had difficulty in standing.</p> <p>Interview with the facility 's director of nursing [DON], qualified mental retardation professional [QMRP], and the residential director [RD] on 1/21/2010 at approximately 11:10 a.m. verified there was no effective monitoring system in place to address the timely reporting of all injuries of unknown origin.</p>	W 153	<p>6. Cross reference W149</p> <p>7. Cross reference W149</p> <p>8. Cross reference W149</p> <p>9. Cross reference W149</p> <p>10. Cross reference W149</p> <p>11. Cross reference W149</p> <p>12. Cross reference W149</p>	<p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p> <p>3/2/10</p>
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

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W 154	Continued From page 9 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to investigate all incidents of unknown origin as required by this section for two of two sampled clients. [Clients #1 and #2] The finding includes: Review of the unusual incident reports and staff interview on 1/12/2010, at 10:24 a.m. and review of the nursing notes on 1/19/2010, at approximately 10:00 a.m. revealed both Clients #1 and #2 were found to have injuries of unknown origin. In addition, interview with the facility 's director of nursing [DON], qualified mental retardation professional [QMRP], the residential director [RD] on 1/21/2010 at approximately 11:12 a.m. revealed there was no investigative reports for the injuries of unknown origin that were documented by the facility for Client #1 on 7/3, 7/24, 7/25, 8/3, 8/18, 8/26, 9/1, 9/9, 9/26, 10/21 of 2009 and for Client #2 on 10/18, 10/19 of 2009. The facility failed to ensure an investigative report was generated after injuries of an unknown source were observed on a client. [Cross Reference W153]	W 154	In the future, the QMRP, Residential Manager and Nursing Staff will ensure an investigative report is generated for all incidents of unknown origin for Client #1 and Client #2.	3/2/10
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 10 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional [QMRP] failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for seven of seven of the clients residing in the facility. [Clients #1, #2] The finding includes: 1. The QMRP failed to ensure that all injuries of unknown origin were reported immediately to the governmental agencies as required by DC Municipal Regulation [22 DCMR Chapter 35 Section 3519.10]. [See W153] 2. The QMRP failed to ensure all injuries of unknown origin are investigated. [See W154] 3. Dinner observation on 1/12/2010 at 5:15 p.m. revealed Client #2's meal of Beef, broccoli, and baked potatoes was served in bite sized pieces. The attending staff was observed cutting the food items into bite sized pieces just prior to her eating. Review of Client #2's 5/1/2009, 8/1/2009, and 11/5/2009 Nutrition assessments on 1/13/2010, at approximately 12:00 p.m. revealed she was recommended for a "chopped" textured diet. In addition, her 1/2010 physician's order sheets revealed she was prescribed a "regular" diet on 3/28/2007. Interview with the qualified mental retardation	W 159	1. Cross reference W122 2. Cross reference W122 3. All staff will receive training on all individual diets and textures. In addition the nutritionist will review assessments for all individuals to ensure accurate information.	3/2/10 3/2/10 3/12/10

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE 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) COMPLETION DATE	
W 159	Continued From page 11 professional [QMRP] on 1/13/2010, at approximately 12:15 p.m. revealed there was no evidence Client #2's nutritional recommendation for a chopped textured diet was clarified with the primary care physician or the Nutritionist. In addition, the QMRP indicated the Nutritionist's recommendation for a chopped diet may have been a typographical error and that Client #2 is capable of eating regular textured meals independently. The QMRP further indicated she would meet with the Nutritionist to review that assessment. The facility's QMRP failed to coordinate services to ensure a client's nutritional needs as recommended. 4. The QMRP failed to ensure staff was effectively trained to employ behavior management plans. [See W193] 5. The QMRP failed to ensure the consistent implementation of a client's behavior support plan (BSP). [See W249] 6. The QMRP failed to ensure all staff properly documented a client's targeted behaviors. [See W252] 7. The QMRP failed to ensure disposable under pads were not being used for the convenience of staff. [See W287]	W 159	4. Cross reference W193 5. Cross reference W249 6. Cross reference W252 7. Cross reference W287	3/19/10 3/5/10 3/19/10 3/5/10	
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.	W 189			

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

PRINTED: 02/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010	
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W 189	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to provide proper food textures and effectively document targeted behaviors for one of four clients residing in the facility. [Clients #3]</p> <p>The finding includes:</p> <p>Dinner observation on 1/12/2010 between the hours of 6:00 p.m. and 7:00 p.m. revealed Client #3's meal was served in large bite sized pieces and Client #3's meal was served whole.</p> <p>Review of Client #3's 4/9/2009, 7/9/2009, 10/10/2009 Nutrition Quarterly reviews revealed she was recommended for a "chopped" textured diet. In addition, her 1/2010 physician's order sheets revealed she was prescribed a "1500 calorie chopped" diet on 7/1/1998.</p> <p>Interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at approximately 12:20 pm revealed there was no evidence of staff training on Client #3's nutritional recommendation for a chopped textured diet.</p> <p>The facility failed to implement effective training on Client #3's altered textured diet as prescribed and as required by this section.</p>	W 189	<div style="border: 1px solid black; padding: 2px;">Cross reference W159 #3</div>	<div style="border: 1px solid black; padding: 2px;">3/12/10</div>
W 193	<p>483.430(e)(3) STAFF TRAINING PROGRAM</p> <p>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p>	W 193		

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

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FORM APPROVED
OMB NO. 0938-0391

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W 193	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement a client's behavior management plan for one of two sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Observation on 1/12/2010 at 12:20 p.m. revealed Client #2 was sitting in a large room with approximately twenty-five other people listening to music at her day program. While she sat there, she was observed picking items off her pants and eating them. It appeared she was tearing lint and thread off her pants and putting them in her mouth. Her assigned "one-on-one" staff from the residential facility was within arm reach of her during the observation, but never made any attempt to redirect the behavior.</p> <p>Record review on 1/14/2010 at approximately 1:20 p.m. revealed Client #2's Behavior Modification Plan [BMP] dated 10/24/2009 listed "pica" and "tearing and shredding" as two of her targeted maledaptive behaviors. The plan outlined that "Staff use verbal redirection and substitution to prevent and stop early-stage pre-aggression behaviors, pica, skin-picking, hair-pulling and non-compliance." The plan further outlined, "If staff recognizes that she sees something that she wants to put in her mouth, then staff should say 'No ...' After a second or two staff should next offer her some sugarless hard candy to suck on ... If she does not stop with verbal instructions to stop, or when verbal redirection fails, then staff may have to use touch control."</p>	W 193		

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

PRINTED: 02/18/2010
FORM APPROVED
OMB NO. 0938-0391

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W 193	Continued From page 14 Interview with the facility 's QMRP on 1/14/2010 at 1:22 p.m. revealed she was not aware the staff was not implementing the BSP and she was also not aware the staff was not documenting Client #2's targeted behaviors on the data sheets.	W 193	The facility will train all staff on Client #2 BSP to ensure targeted behaviors are redirected and documented.	3/19/10
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the implementation of a toileting program to address a client's lack of toileting skills for one of two sampled clients. [Client #1] The finding includes: On the afternoon of 1/12/2009 at approximately 6:00 p.m., Client #1's attending staff assisted her up from her chair, and helped her walk to the restroom. Another staff mopped up the floor beneath where she was seated at the dinner table while Client #1 was being assisted to the restroom. As Client #1 walked past her	W 242	The facility will implement a toileting schedule for Client #1 and assess the need for disposable diapers.	3/5/10

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

PRINTED: 02/16/2010
FORM APPROVED
OMB NO. 0938-0391

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W 242	Continued From page 15 housemates, who were sitting in the living room at the time, there was a large wet stain on the back of her denim slacks. At approximately 6:15 p.m., staff aided Client #1 to return to the living room by assisting her to walk back to her wheelchair to wait for the evening medication nurse. A set of disposable under pads was observed underneath her while she sat in the wheelchair. Interview with staff after dinner on the same day at approximately 6:45 p.m. revealed Client #1 wets herself quite often as her health has declined over the past several months. Further interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at 4:16 p.m. revealed there was no system in place to address Client #1's incontinence apart from using the disposal pads and cleaning her up after she wets herself. Record review revealed there was no evidence presented or on file at the time of survey to substantiate that a toileting program was developed or in place to address Client #1's incontinence.	W 242			
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.	W 249			

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

PRINTED: 02/16/2010
FORM APPROVED
OMB NO. 0938-0391

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W 249	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement a client's behavior support plan to ensure their health and safety for one of two sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Observation on 1/12/2010 at 12:20 p.m. revealed Client #2 was sitting in a large room with approximately twenty-five other people listening to music at her day program. While she sat there, she was observed picking items off her pants and eating them. It appeared she was tearing lint and thread off her pants and putting them in her mouth. Her assigned "one-on-one" staff from the residential facility was within arm reach of her during the observation, but never made any attempt to redirect the behavior.</p> <p>According to her behavior support plan dated 10/24/2009, this behavior was not addressed and the staff failed to implement the plan accordingly. [See W193]</p>	W 249	<div style="border: 1px solid black; padding: 5px;">Cross reference W193</div>	3/19/10
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the implementation of an effective system of documenting the frequency of targeted behaviors</p>	W 252		

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

PRINTED: 02/16/2010
FORM APPROVED
OMB NO. 0938-0391

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W 252	Continued From page 17 as recommended for one of two sampled clients. [Client #2] The finding includes: Client #2 was observed picking and pulling at her pants and eating the items [appeared to be lint and string] while at her day program on 1/12/2010 at approximately 12:20 p.m. Record review on 1/14/2010 at approximately 1:20 p.m. revealed Client #2 ' s Behavior Modification Plan [BMP] dated 10/24/2009 listed " pica " and " tearing and shredding " as two of her targeted maladaptive behaviors. A review of Client #1 ' s 1/2010 data collection sheet on the same day and time revealed there was no data collected for the maladaptive behaviors that were observed on 1/12/2010. Further record review and interview with the facility ' s qualified mental retardation professional [QMRP] on 1/14/2010 at approximately 1:24 p.m. revealed she was not aware the staff was not documenting Client #2 ' s targeted behaviors on the data sheets. The facility failed to ensure staff accurately documented Client #2 ' s targeted behaviors as outlined by the BMP.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.	W 262	Staff will receive additional training on the dely documentation of target behaviors for Client #1 and #2.	3/18/10

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

PRINTED: 02/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
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W 262	<p>Continued From page 18</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the Human Right Committee 's oversight and approval for the use of psychotropic medication for one of two sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>Observation on the evening of 1/12/2010 at approximately 7:30 p.m. revealed the evening medication nurse provided Client #1 her evening dosage of Zyraxa [20mg tab].</p> <p>Record review on 1/13/2010 at approximately 9:30 a.m. revealed Client #1 ' s psychotropic medications were increased as follows:</p> <ol style="list-style-type: none"> 1. Psychiatry assessment dated 4/21/2009 prescribed "DC Risperdal, add Zyraxa 5mg 2x day/orally " . 2. Psychiatry assessment dated 5/19/2009 prescribed to " increase Zyraxa to 15mg at bed " . 3. Psychiatry assessment dated 6/16/2009 prescribed to " increase Zyraxa to 20mg orally at bed and to increase Seroquel to 300mg in AM " . The original order for Seroquel was 200mg in the morning for the months of 4/2009 and 5/2009. <p>Interview with the facility's registered nurse [RN] and qualified mental retardation professional [QMRP] on 1/13/2010 at approximately 9:40 a.m. revealed the Zyraxa and the Seroquel was prescribed to manage Client #1's maladaptive behaviors.</p>	W 262	<div style="border: 1px solid black; padding: 5px;"> <p>In the future, the QMRP will have the Human Rights Committee review the use of psychotropic medications for Client #1 whenever there is a dosage or medication change.</p> </div>	3/2/10

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

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FORM APPROVED
OMB NO. 0938-0391

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W 262	Continued From page 19	W 262		
W 267	Record review on the same day and time revealed there was no evidence presented or on file at the time of survey to substantiate that the Human Rights Committee met to approve the administration and the increase of these psychotropic medications. 483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the implementation of a procedure to address a client's incontinence for one of two sampled clients. [Client #1] The finding includes: On the afternoon of 1/12/2009 at approximately 6:00 p.m., Client #1's attending staff lifted her up from her chair, took her to the restroom as another staff mopped up the floor beneath where she was seated at the dinner table. As she walked past her housemates who were sitting in the living room at the time, there was a large wet stain on the back of her denim slacks. Interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at 4:16 p.m. revealed there was no procedure in place to address Client #1's incontinence apart from using the disposal pads and cleaning her up after she wets herself to ensure her personal rights. [See W242]	W 267	A procedure will be developed to address her incontinence. Cross reference W242	3/5/10 3/5/10
W 287	483.450(b)(3) MGMT OF INAPPROPRIATE	W 287		

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

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W 287	Continued From page 20 CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure disposable under pads/chucks were not being used for staff convenience to address a client's lack of bowel control for one of two sampled clients. [Client #1] The finding includes: On the afternoon of 1/12/2009 at approximately 8:00 p.m., Client #1 was observed sitting on a disposable pad prior to her wetting herself. Interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at 4:16 p.m. revealed there was no effective system in place to address Client #1's lack of bowel control apart from using the disposable pads. [See W287]	W 287	Cross reference W242	3/5/10
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 failed to ensure the timely assessment and monitoring of a client's recurring injuries of unknown origin to ensure her health and safety for one of two sampled clients. [Client #1]	W 322		

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

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W 322	Continued From page 21 The finding includes: [Cross Reference W149] The facility failed to implement an effective procedure to monitor patterns of repeated falls and injuries of unknown origin to ensure clients health and safety as evidenced below. interview with the facility's qualified mental retardation professional [QMRP] and director of nursing [DON] on 1/18/2010 at approximately 11:05 a.m. verified there was only three physician's (PCP) assessments on file at the time of survey. The three assessments were dated 10/5/2009, 10/23/2009, and 1/8/2010. Further interview with the DON on the same date and time revealed the PCP assessed Client #1 on 10/5/2009 to address an injury of unknown origin. The DON further clarified the 10/23/2009 assessment was a "sick visit" and the 1/8/2010 quarterly assessment was conducted to address Client #1's decreased mobility and to request a review of her psychotropic regimen. There was no written documentation on file at the time of survey to substantiate that timely reviews and assessments of Client #1's recurring falls and injuries were made by the primary care physician.	W322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide nursing services in accordance with the needs of one of the two clients in the	W 331	Cross reference W122	3/2/10

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

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W 331	<p>Continued From page 22 sample. [Client #1]</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. [Cross reference W149] There was no documented evidence the nursing staff ensured the pattern of repeated injuries of unknown origin were properly assessed to rule out neglect or abuse. In addition, there was no documented evidence that the nursing staff ensured this information was relayed to the primary care physician. 2. Review of Client #1's daily nursing notes on 1/19/2010 at approximately 10:00 a.m. revealed there was no evidence the primary care physician (PCP) was being notified of the repeated health concerns as evidence below: <ol style="list-style-type: none"> a. 7/3 Nursing Note - pain, discomfort, weakness and shaking of left leg. b. 7/3 Nursing Note - Client #1 sleeping all day except for meals; RN on call advised [evening medication nurse] to hold Zyprexa in PM; Client #1 was sedated for a medical appointment the day before. c. 8/2009 Monthly Nursing Summary - Irregular BM despite use of Lactulose; Client taken to ER on 8/28 due to fall and sprain, had multiple abrasions; medium risk for falls/fractures. d. 8/11 Nursing Note - returned home from day program drowsy, slouching in class, runny nose, red eyes. e. 8/12 Nursing Note - red eyes, runny nose, 	W 331			

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

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W331	<p>Continued From page 23</p> <p>loss of sleep, dizziness. In PM, alert, combative with one of the residents.</p> <p>f. 8/14 Nursing Note - red eyes, loss of sleep, dizziness, excessive cloudy urine, hunched over in cless - notified the Director of Nursing (DON).</p> <p>g. 8/14 Nursing Note - excessive urination, cloudy urine, sitting hunched over in chair. Staff confirmed this is not her usual posture when sitting in a chair.</p> <p>h. 9/2009 Monthly Nursing Summary - Moderate involuntary muscle movements had been observed on [Client] and she is sometimes observed sleepy during daytime ... Observed lethargic and dependent on use of wheelchair/LE swollen; seen by Psychiatrist 9/1 - ordered to continue present treatment, medium risk for falls/fractures.</p> <p>i. 9/25 Nursing Note - Client #1 complainad of right leg pain at her day program.</p> <p>j. 10/2009 Monthly Nursing Summary - Still lethargic end dependent on use of wheelchair/LE swollen; irregular BM, medium risk for falls/fractures. Aspirin was discontinued on 10/08/09 by Primary Care Physician (PCP) due to easy bruising.</p> <p>k. 10/3 Nursing Note - loose stool and abdominal discomfort; Lactulose held this morning (AM).</p> <p>l. 10/22 - Nursing Note - she was moderately lethargic; sitting in W/C hunched over.</p> <p>m. 10/28 Nursing note - " she was dropping to</p>	W331		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE 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) COMPLETION DATE
W 331	Continued From page 24 the floor when being taken to the bathroom " n. 11/2009 Monthly Nursing Summary - Still lethargic and dependent on use of wheelchair/LE swollen, irregular BM despite daily dosage of Enulose; madium risk for falls/fractures; declining overall health status. Neurology appointment due next month. Interview with the facility ' s qualified mental retardation professional and the director of nursing on 1/21/2010 at 10:25 p.m. verified there was no documented evidence on record to substantiate that the primary care physicien was being informed of these documented health concerns. The facility nursing staff failed to ensure an effective system of oversight, monitoring and coordination of services was in place to ensure Client #1's health and safety.	W 331	Cross reference W122	3/2/10
W 474	483.480(b)(2)(III) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients were provided their meals in a texture prescribed by the Nutritionist for one of four clients residing in the facility. [Clients #3] The finding includes: Dinner observation on 1/12/2010 between the hours of 6:00 p.m. and 7:00 p.m. revealed Client #3's meal was served in large bite sized pieces and Client #3 ' s meal was served whole.	W 474		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20019	
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W 474	Continued From page 25 Review of Client #3's 4/9/2009, 7/9/2009, 10/10/2009 Nutrition Quarterly reviews revealed she was recommended for a "chopped" textured diet. In addition, her 1/2010 physician's order sheets revealed she was prescribed a "1500 calorie chopped" diet on 7/1/1998. Interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at approximately 12:21 pm revealed she was not aware of Client #3's Nutritionist's recommendation for a chopped textured diet. The facility failed to ensure staff provided Client #3 her meals in an altered texture as recommended and as required by this section.	W 474	Cross reference W159 #3	3/12/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		
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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 1/12/2010 through 1/14/2010. A random sampling of two residents was selected from a population of four females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the habilitation and administrative records, including the incident reports.	I 000		
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 staff interview and record review, the GHMRP's qualified mental retardation professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for seven of seven of the residents residing in the GHMRP. [Residents #1, #2] The finding includes: 1. The QMRP failed to ensure that all injuries of unknown origin were reported immediately to the governmental agencies as required by DC Municipal Regulation [22 DCMR Chapter 35 Section 3519.10]. [See Federal deficiency report citation W153] 2. The QMRP failed to ensure all injuries of unknown origin are investigated. [See Federal deficiency report citation W154]	I 183	1. Cross reference W153 2. Cross reference W154	3/2/10 3/2/10

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

STATE FORM

Carstene A. Reese

Program Director

TITLE

(X5) DATE

2/24/10

TUY111

If continuation sheet 1 of 10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2010
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I 183	<p>Continued From page 1</p> <p>3. Dinner observation on 1/12/2010 at 5:15 p.m. revealed Resident #2 a meal of Beef, broccoll, and baked potatoes was served in bite sized pieces. The attending staff was observed cutting the food items into bite slzed pieces just prior to her eating.</p> <p>Review of Resident #2's 5/1/2009, 8/1/2009, and 11/5/2009 Nutrition assessments on 1/13/2010, at approximately 12:00 p.m. revealed she was recommended for a "chopped" textured diet. In addition, her 1/2010 physician's order sheets revealed she was prescribed a "regular" diet on 3/28/2007.</p> <p>Intarview with the qualified mental retardation professional [QMRP] on 1/13/2010, at approximately 12:15 p.m. revealed there was no evidence Resident #2's nutritional recommendation for e chopped textured diet was clarified with the primary care physician or the Nutritionist.</p> <p>In addition, the QMRP indicated the Nutritionist's recommendation for a choppad diet may have been a typogrephical error and that Resident #2 is capable of eating regular textured meals Independantly. The QMRP further indicatad she would meet with the Nutritionist to review that assessment.</p> <p>The facility's QMRP failed to coordinate services to ensure a resident's nutritional needs as recommended.</p> <p>4. The QMRP failed to ensure staff was effectively trained to employ behavior management plans. [See Federal deficiency report citation W193]</p>	I 183	<p>3. Cross reference W159</p> <p>4. Cross reference W193</p>	<p>3/12/10</p> <p>3/19/10</p>

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I 183	Continued From page 2 5. The QMRP failed to ensure the consistent implementation of a resident's behavior support plan (BSP). [See Federal deficiency report citation W249] 6. The QMRP failed to ensure all staff properly documented a resident's targeted behaviors. [See Federal deficiency report citation W252] 7. The QMRP failed to ensure disposable under pads were not being used for the convenience of staff. [See Federal deficiency report citation W287]	I 183	5. Cross reference W193 6. Cross reference W252 7. Cross reference W287	3/19/10 3/19/10 3/5/10
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was provided a written job description as required by this section. [Staff #1, #2, #5, #7, #9 and #12] The finding includes: Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 1/14/2010 at approximately 10:45 a.m. revealed six out of twelve staff was without a written job description in their personnel files.	I 202	All staff will be provided a written job description in their profile and signed annually.	3/19/10
I 203	3509.3 PERSONNEL POLICIES	I 203		

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I 203	Continued From page 3 Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure six out of twelve staff was provided the opportunity to annually review their written job descriptions as required by this section. [Staff #1, #2, #5, #7, #9 and #12] The finding includes: Record review and interview with the GHMRP 's qualified mental retardation professional (QMRP) on 1/14/2010 at approximately 10:46 a.m. revealed six out of twelve staff was not provided the opportunity to review their written job description over the past licensure year. [Cross Reference Licensure Citation 3509.2]	I 203	Cross reference 1202	3/18/10
I 206	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 record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure four of twelve staff secured an annual health inventory as required by this section. [Staff #1, #5, #9 and #12]	I 206	All staff will have current physicals completed annually. OMRP and Residential Manager will review personnel folders quarterly for current physicals.	3/18/10

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I 206	Continued From page 4 The finding includes: Record review and interview with the GHMRP 's qualified mental retardation professional (QMRP) on 1/14/2010 at approximately 10:55 a.m. revealed four out of twelve staff did not have a current health inventory on file.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure staff was effectively trained to ensure proper food textures and documenting targeted behaviors for two of four residents residing in the GHMRP. [Residents #2 and #3] The finding includes: Dinner observation on 1/12/2010 between the hours of 6:00 p.m. and 7:00 p.m. revealed Resident #3's meal was served in large bite sized pieces and Resident #3's meal was served whole. Review of Resident #3's 4/9/2009, 7/9/2009, 10/10/2009 Nutrition Quarterly reviews revealed she was recommended for a "chopped" textured diet. In addition, her 1/2010 physician's order sheets revealed she was prescribed a "1500 calorie chopped" diet on 7/1/1998. Interview with the qualified mental retardation professional (QMRP) on 1/13/2010 at approximately 12:20 pm revealed there was no	I 222	Cross reference W183	2/26/10

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2536 MYRTLE AVENUE 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 222	Continued From page 5 evidence of staff training on Resident #3's nutritional recommendation for a chopped textured diet. The facility failed to implement effective training on Resident #3's altered textured diet as prescribed and as required by this section. [See Federal deficiency report citation W189]	I 222	Cross reference W189	3/12/10
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement a resident's behavior management plan for one of two sampled residents. [Resident #2] The finding includes: Observation on 1/12/2010 at 12:20 p.m. revealed Resident #2 was sitting in a large room with approximately twenty-five other people listening to music at her day program. While she sat there, she was observed picking items off her pants and eating them. It appeared she was tearing lint and thread off her pants and putting them in her mouth. Her assigned "one-on-one" staff from the residential facility was within arm reach of her during the observation, but never made any attempt to redirect the behavior.	I 229	Cross reference W183	3/19/10

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2336 MYRTLE AVENUE NE WASHINGTON, DC 28018		
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I 229	<p>Continued From page 6</p> <p>Record review on 1/14/2010 at approximately 1:20 p.m. revealed Resident #2 's Behavior Modification Plan (BMP) dated 10/24/2009 Resident #2 's Behavior Modification Plan (BMP) dated 10/24/2009 listed " pica " and " tearing and shredding " as two of her targeted mal-adaptive behaviors. The plan outlined that " Staff use verbal redirection and substitution to prevent and stop early-stage pre-aggression behaviors, pica, skin-picking, hair-pulling and non-compliance. " The plan further outlined, " If staff recognizes that she sees something that she wants to put in her mouth, then staff should say ' No ... ' After a second or two staff should next offer her some sugarless hard candy to suck on ... If she does not stop with verbal instructions to stop, or when verbal redirection fails, then staff may have to use touch control. "</p> <p>Interview with the facility ' s QMRP on 1/14/2010 at 1:22 p.m. revealed she was not aware the staff was not implementing the BSP and she was also not aware the staff was not documenting Resident #2 ' s targeted behaviors on the data sheets.</p> <p>The facility failed to ensure staff was effectively trained on Resident #2 ' s behavior management plan as required by this action.</p>	I 229		
I 379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall</p>	I 379		

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I 379	Continued From page 7 be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by this section to protect the health and safety of two of two sampled residents. [Residents #1 and #2] The findings include: Review of Resident #1's daily nursing notes on 1/19/2010 at approximately 10:00 a.m. revealed several notations of injuries of unknown origin were documented in 2009. A synopsis of the nursing entries is presented below: 1. 7/1/09 - Staff stated Resident #1 fell on her left side in the dining room; assessed by the nurse and was found to show no signs of injury/pain; scalp abrasion appeared clear/dry. 2. 7/3/09 - Nursing Note - pain, discomfort, weakness and shaking of left leg. Purpia skin coloration on right breast approximately 2.5 x 2cm. 3. 7/20/09 - Day Program Nursing Note - bruise on right arm near her elbow, approximately 3 cm by 2 cm in diameter; red and black in color. 4. 7/24/09 - Day Program Nursing Note - Resident #1 complained of back pains and was assessed to have two large bruises on the lower part of her back. The bruise on the left side measured 2 inches and the right side bruise measured 3 inches in width. The bruises were	I 379		

Health Regulation Administration

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I 379	<p>Continued From page 8</p> <p>purple, yellow and green in color.</p> <p>5. 7/25/09 - Nursing Note - purple coloration on right hand / upper arm. Two (2) purple colorations above buttocks.</p> <p>6. 8/3/09 - Day Program Nursing Note - Complained of back pains and bruise to right upper posterior of forearm.</p> <p>7. 8/18/09 - Day Program Nursing Note - presents with a scratch the size of a pencil eraser to right forearm.</p> <p>8. 8/28/09 - Nursing Note - Emergency Room [ER] visit for an injury which occurred in the morning [AM]; prominent abrasion to right scapula, upper mid back and neck.</p> <p>9. 9/1/09 -Nursing Note - right of back and upper scapula abrasions resolved.</p> <p>10. 9/9/09 - Day Program Nursing Note - Bruise on right arm; staff noticed it when she took her sweater off.</p> <p>11. 9/26/09 - Nursing Note - large bruise above buttocks in center of back and dime sized old bruise on left buttocks.</p> <p>12. 10/21/09 - Nursing Note - bruise on upper right thigh; refused and also had difficulty in standing.</p> <p>Interview with the facility's director of nursing [DON], qualified mental retardation professional [QMRP], and the residential director [RD] on 1/21/2010 at approximately 11:10 a.m. verified there was no effective monitoring system in place to address the timely reporting of all injuries of unknown origin.</p> <p>There was no documented evidence the GHMRP reported these injuries of unknown origin immediately to the administrator or the District Department of Health (DOH) as required by this section. [Cross reference Federal deficiency report citations W153 and W154]</p>	I 379	<div style="border: 1px solid black; padding: 5px; width: fit-content;">Cross reference W154</div>	<div style="border: 1px solid black; padding: 5px; width: fit-content;">3/2/10</div>

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I 500	Continued From page 9	I 500		
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 staff interview, the facility failed to ensure the implementation of a procedure to address a resident's incontinence for one of two sampled residents. [Resident #1] The finding includes: On the afternoon of 1/12/2009 at approximately 6:00 p.m., Resident #1 's attending staff lifted her up from her chair, took her to the restroom as another staff mopped up the floor beneath where she was seated at the dinner table. As she walked past her housemates who were sitting in the living room at the time, there was a large wet stain on the back of her denim slacks. Interview with the qualified mental retardation professional [QMRP] on 1/13/2010 at 4:16 p.m. revealed there was no procedure in place to address Resident #1's incontinence apart from using the disposal pads and cleaning her up after she wats herself to ensure her personal rights. [See Federal deficiency report citation W267]	I 500		
			Cross reference W267	3/5/10