

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/02/2010
--	--	--	---

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 000)	<p>INITIAL COMMENTS</p> <p>A revisit was conducted from 3/2/2010 through 3/2/2010 to address the Conditions of Participation in Client Protections. A sampling of two residents, one new and one from the previous survey, was selected from a population of four females with varying degrees of disabilities.</p> <p>The findings of the survey were based on observations and interviews in the home, as well as a review of the client and administrative records, including the incident reports.</p> <p>Based on the findings, the facility was found to be in substantial compliance with the Conditions of Participation in Client Protections.</p> <p>W 369 483.480(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure its system for medication administration assured that all medications were administered without error for one to two client in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. On 3/2/2010, at 8:40 a.m., the medication nurse was observed to administer Client #2 Alendronate Sodium tablet 70 mg with a glass of water. Interview with the nurse at this time revealed that the client was prescribed the medication one time a week for osteoporosis.</p>	(W 000)	<p>CMS Nursing and group home staff will receive additional training on Client #2 medication for osteoporosis, and how it should be administered before breakfast every Tuesday. Instructions for group home staff will be posted as a reminder.</p> <p><i>Received 3/22/10</i></p> <p>W 369 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 1000 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	3/30/10
---------	--	---------	---	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cantance A. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>3/19/10</i>
---	----------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 03/12/2010
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 R 03/02/2010
--	---	--	---

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 369	<p>Continued From page 1</p> <p>On 3/2/2010, at 8:42 a.m., review of the instructions on the label revealed the client was to be administered the medication one time a week for osteoporosis. Continued review of the label on the medication revealed the client was to receive the medication on Tuesday upon awakening, 30 minutes prior to breakfast, with a full glass of water....</p> <p>On 3/2/2010, at 8:44 a.m., review of the medication administration record (MAR) revealed the medication was scheduled to be administered at 8:30 a.m. Verification of the physician's order dated, 3/2/2010 at 8:41 a.m. revealed, "Alendronate Sodium 70 mg (Sub Fosamax weekly) ** Tuesday ** 1 tablet by mouth** Every week** For osteoporosis", upon awakening 30 minutes prior to breakfast with a full glass of water, and sit upright 30 minutes after dose is given"</p> <p>On 3/2/2010, at 8:46 a.m., interview with staff revealed that the clients had eaten breakfast at 7:15 a.m. The staff indicated that the clients usually started eating breakfast between 7:00 a.m. and 7:15 a.m.</p> <p>Although the medication was administered at the hour noted on the MAR (8:30 a.m.), there was no evidence it was given in accordance with the time frame prescribed in the physician's orders.</p> <p>2. On 3/2/2010, beginning at 8:30 a.m., the LPN was observed to administer Client #2's morning medications.</p> <p>On 3/2/2010 from 8:29 a.m., to 8:40 a.m., the medication nurse was observed administering Client #2's oral medications.</p>	W 369	<p>2. Disciplinary action was taken and the LPN was required to attend training on documentation and provide evidence of attending the training. (see attached sheet)</p>	3/2/10
-------	--	-------	---	--------

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/02/2010
--	--	--	---

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 369	<p>Continued From page 2</p> <p>On 3/2/2010, at 8:50 a.m., review of the medication administration record and the corresponding physician's orders revealed, the client was also prescribed "Artificial Tears Opth drops, Instill 2 drops in each eye twice daily." The client was not observed to be administered eye drops during the medication administration.</p> <p>Interview with the medication nurse on 3/2/2010, at 8:52 a.m., revealed the eye drops were prescribed for dry eyes. Further discussion with the medication nurse, however, revealed that the administration of the eye drops had been inadvertently omitted. At the time of the survey, there was no evidence Client #2 had received each prescribed medication.</p>	W 369		

PRINTED: 03/12/2010
FORM APPROVED

Health Regulation Administration

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 R 03/02/2010
--	--	--	---

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) COMPLETE DATE
(1 000)	<p>INITIAL COMMENTS</p> <p>A revisit was conducted from 3/2/2010 through 3/2/2010. A sampling of two residents, one new and one from the previous survey was selected from a population of four females with varying degrees of disabilities.</p> <p>The findings of the survey were based on observations and interviews in the home, as well as a review of the habilitation and administrative records, including the incident reports.</p>	(1 000)		

Health Regulation Administration

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

STATE FORM

Constantine A. Reese

TITLE *Program Director* (X5) DATE *3/19/10*

TUY112

If continuation sheet 1 of 1