

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/06/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 13TH STREET NW WASHINGTON, DC 20010</b>
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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
W 000	INITIAL COMMENTS  A re-certification survey was conducted from 4/4/2012 through 4/8/2012. The survey was completed utilizing the fundamental survey process.  A random sampling of four clients was selected from a residential population of seven males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the unusual incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review revealed, Client #3's day program failed to implement programming objectives as written for one of four sampled clients. [Client #3]  Observation on 4/5/2011 at 1:10 p.m. revealed Client #3 was assigned to be in the computer room after lunch. Interview with the instructor in the computer room beginning at approximately 1:13 p.m. revealed Client #3 takes part in putting together a 48 piece large block puzzle at least three times a week. The instructor indicated	W 120	QIDP will ensure that instructors at Individual #3's day program will be trained on the implementation of programming objectives as written. QIDP will visit day program quarterly to ensure implementation of objectives are upheld.	5/7/12

*RECEIVED 5/3/12*  
 Department of Health  
 Health Regulation & Licensing Administration  
 Intermediate Care Facilities Division  
 809 North Capitol St., N.E.  
 Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese TITLE: Program Director (X6) DATE: 5/3/12

Each 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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PHIN TEL: 04/24/2012  
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(M) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	<p>Continued From page 1</p> <p>using the puzzle allows Client #3 to focus on a task. The instructor also indicated that Client #3 does not use the computers that are in the classroom for any activities. He stated that all Client #3's activities are completed with items he can physically manipulate.</p> <p>Record review on 4/6/2012 at approximately 1:00 p.m., revealed Client #3's day treatment assessment (3rd Quarter 7-9/2011) outlined the following objective which read, " Given verbal prompts and physical assistance when necessary, [Client #3] will use a computer to assemble a simple 4,6,8,12 piece puzzle each day. "</p> <p>Interview with the qualified intellectual disability professional (QIDP) and the House Manager (HM) on 4/6/2012 at approximately 5:30 p.m. revealed they were not aware the day program staff was not allowing Client #3 to take part in any computer related activities. The QIDP indicated she planned to visit the day program to address the oversight.</p>	W 120		
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility failed to ensure all outside services were implemented as written.</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a full and accurate</p>	W 140		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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FINAL SURVEY  
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W 140	<p>Continued From page 2</p> <p>accounting of client ' s funds for four of seven clients residing in the facility. [Clients #1, #5, #6, and #7]</p> <p>Record review on 4/5/2012 beginning at 10:15 a.m. revealed the following financial discrepancies:</p> <ol style="list-style-type: none"> <li>Client #5 took part in a three day vacation with three of his housemates which began on 8/7/2011 and ended on 8/10/2011. The financial records listed that \$225.00 was allocated for food during this three day outing. Review of the receipts on 4/5/2012 at 11:11 a.m. revealed only \$64.44 was accounted for.</li> <li>Client #7 took part in a three day vacation with three of his housemates which began on 8/7/2011 and ended on 8/10/2011. The financial records listed that \$225.00 was allocated for food during this three day outing. Review of the receipts on 4/5/2012 at 11:28 a.m. revealed only \$105.87 was accounted for.</li> <li>Client #1 took part in a three day vacation with three of his housemates which began on 8/7/2011 and ended on 8/10/2011. The financial records listed that \$225.00 was allocated for food during this three day outing. Review of the receipts on 4/5/2012 at 11:44 a.m. revealed only \$60.99 was accounted for.</li> <li>Client #6 took part in a three day vacation with three of his housemates which began on 8/7/2011 and ended on 8/10/2011. The financial records listed that \$225.00 was allocated for food during this three day outing. Review of the receipts on 4/5/2012 at 11:56 a.m. revealed only</li> </ol>	W 140		

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W 140	<p>Continued From page 3 \$89.91 was accounted for.</p> <p>Interview with the qualified intellectual disability professional (QIDP) and the house manager (HM) on 4/5/2012 at approximately 12:00 p.m. revealed the HM also took an accounting of the receipts on hand and calculated that the totals found by the survey team for Clients #1, #5, #6 and #7 were accurate. The QIDP indicated she would meet with the HM and the management team at their main office to see if she could secure the missing receipts.</p> <p>There was no evidence presented or on file at the time of survey to substantiate that the facility ensured an accurate accounting of all clients' expenditures.</p>	W 140	<p>Missing food receipts for the 3-day trip to Atlantic City for Individuals #1, #5, #6, and #7 will be presented as evidence and placed in each Individuals Finance records. In the future any purchases not having a receipt at the time of purchase will be documented by using a receipt book as proof of purchase. Reimbursement will be made for all funds unaccounted for this trip.</p>	5/21/12
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of four sampled clients. (Clients #2, #3 and #4)</p> <p>The findings include:</p> <p>1. Client #3 was assigned to take part in a cognitive skills program which required him take part in assembling a puzzle by using a computer</p>	W 159	<p>1. Cross Reference W120</p>	5/7/12

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W 159	<p>Continued From page 4</p> <p>puzzle program. The program was required to be performed daily. Observation on 4/5/2011 at 1:10 p.m. at Client #3's day program and interview with his primary classroom staff revealed, Client #3 was never allowed to interact with any of the computers in his computer class. Interview with the qualified intellectual disability professional (QIDP) on 4/6/2012 at approximately 5:30 p.m. revealed she were not aware the day program staff was not allowing Client #3 to use the computer. The QIDP indicated she planned to visit the day program to address the oversight. (Reference W120 and W249)</p> <p>2. Record review on 4/5/2012 beginning at 10:15 a.m. revealed Clients #1, #5, #6, and #7 went on vacation between the dates of 8/7/2011 and 8/10/2011. The facility allocated \$225.00 for each client to cover meals over the four days. Review of all four clients' financial records on 4/5/2012 beginning at 10:15 a.m. revealed over \$100.00 worth of receipts was missing from each of these clients records. The QIDP indicated she would meet with the house manager and management staff at their main office to get copies of the missing receipts and to address the oversight. (Reference W140)</p> <p>3. Observation on 4/4/2012 revealed Staff #6 and Staff #9 failed to ensure that Client #4's gait belt was securely fastened to his waist and failed to ensure that the proper technique to support him when he walked around his environment was utilized as prescribed. A review of Client #4's Mobility Training dated 4/6/2012 revealed both staff failed to accurately implement Client #4's ambulation protocol. Interview with the facility's qualified intellectual disability professional (QIDP)</p>	W 159	<p>2. Cross Reference W140</p> <p>3. Cross Reference W194 #1</p>	<p>5/21/12</p> <p>5/7/12</p>

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W 159	<p>Continued From page 5</p> <p>revealed training on ambulation protocols were completed on 4/6/2012 for all staff, but as observed on 4/4/2012, the training was not effective to address Client #4 's needs. (Reference W194 and W436)</p> <p>4. Observation on 4/4/2012 beginning at 4:55 p.m. revealed Client #2 was observed eating his meal. He slumped over his plate throughout his meal and was observed taking a few sips from a small cup at the end of his meal. Record review on 4/6/2012 at approximately 3:00 p.m. revealed Client #2 ' s Feeding Protocol dated 3/16/2012 recommended that he take sips of his beverage throughout his meal and that he be seated at 90 degrees with his head in an upright neutral position. Interview with the QIDP revealed she would work with the staff and provide additional training on Client #2 ' s mealtime feeding protocol. (See W194)</p> <p>5. Observation on 4/4/2012 at approximately 4:57 p.m. revealed Client #3 ' s was observed yelling/screaming and running to the couch on three separate occasions. Review of Client #3 ' s Psychological Evaluation dated 11/29/2011 revealed yelling/screaming and running was one of the targeted behaviors that was to be documented on the data collection sheets. None of the behaviors observed on 4/4/2012 were documented. The QIDP failed to ensure that staff accurately documented data relative to clients' behavioral data, for one of the four sampled clients. (Reference W252)</p>	W 159	<p>4. Cross Reference W194 #2</p> <p>5. Cross Reference W252</p>	<p>5/7/12</p> <p>5/31/12</p>
W 194	<p>483.430(e)(4) STAFF TRAINING PROGRAM</p> <p>Staff must be able to demonstrate the skills and techniques necessary to implement the individual</p>	W 194		

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W 194	<p>Continued From page 6</p> <p>program plans for each client for whom they are responsible.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's staff failed to ensure accurate implementation of a client's mealtime feeding protocol and use of a gait belt for two of four sampled clients. [Client #2 and #4]</p> <p>The findings include:</p> <p>1. Observation on 4/4/2012 beginning at 4:10 p.m. revealed Client #4's gait belt was very loose around his waist. The belt moved freely around his waist when Staff #6 grabbed it to help him walk around. It was also observed that Staff #6 held him by the shoulders, by his arm, and under his arms at different times during the evening. Staff #9 was also observed later in the evening walking on either side of him and/or from behind while supporting him while he walked around.</p> <p>Record review on 4/6/2012 at approximately 2:30 p.m. revealed Client #4's Mobility Training dated 4/8/2012 recommended the following:</p> <p>a. Fasten the gait belt around the resident's waist with the buckle placed in front of the resident.</p> <p>b. The belt should fit snugly, but you should be able to slip your fingers between the belt and the resident's waist.</p> <p>c. Place one hand on the portion of the gait belt at the front of the resident's waist and place your</p>	W 194	<p>1. Staff will be trained on the use of Client #4's gait belt by the primary care nurse. QIDP and Residential Manager will ensure accurate implementation of the gait belt by monitoring usage daily.</p>	5/7/12

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W 194	<p>Continued From page 7</p> <p>hand on the portion of the gait belt at the resident's back.</p> <p>None of the staff working with Client #4 was observed implementing the above protocols as recommended. Interview with the facility's qualified intellectual disability professional (QIDP) and house manager (HM) confirmed training on ambulation protocols were completed on 4/8/2012 for all staff, but the training was not specific to Client #4's needs.</p> <p>The facility failed to ensure staff was competent in implementing Client #4's ambulation protocol with regards to the use of his gait belt.</p> <p>2. Observation on 4/4/2012 beginning at 4:55 p.m. revealed Client #2 was observed eating dinner. Client #2 was observed eating his meal and was offered his fluids at the end of the meal. Client #2 was also observed leaning forward with his head over his plate as he ate with staff assistance.</p> <p>Record review on 4/6/2012 at approximately 3:00 p.m. revealed Client #2's Feeding Protocol dated 3/16/2012 recommended the following:</p> <p>a. Liquids: allow him to take sips of the beverage throughout the meal.</p> <p>b. Positioning: position [Client #2] in his chair at 90 degrees for all meals; ensure that his head is in an upright, neutral position.</p> <p>The staff working with Client #2 was not observed implementing the above protocols. Interview with the facility's QIDP and HM on 4/6/2012 at</p>	W 194	<p>2. Staff will be trained on the implementation of the mealtime protocol for Individual #2. QIDP and House Manager will ensure accurate implementation by monitoring during mealtime.</p>	5/7/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED  04/06/2012
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W 194	Continued From page 8 approximately 3:20 p.m. confirmed the surveyor's observation and indicated training would be scheduled to address the deficient practice.	W 194		
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, staff interview and record review, the facility failed to ensure the implementation of a client's cognitive program in accordance with the approved individual program plan (IPP) for one of three sampled clients. [Client #31</p> <p>Observation on 4/5/2011 at 1:10 p.m. revealed Client #3 was assigned to be in the computer room after lunch. Interview with the instructor in the computer room beginning at approximately 1:13 p.m. revealed Client #3 takes part in putting together a 48 piece large block puzzle at least three times a week. The instructor indicated using the puzzle allows Client #3 to focus on a task. The instructor also indicated that Client #3 does not use the computers that are in the classroom for any activities. He stated that all Client #3's activities are completed with items he can physically manipulate.</p>	W 249	Cross Reference W120	5/7/12

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W 249	Continued From page 9 Record review on 4/6/2012 at approximately 1:00 p.m., revealed Client #3 's day treatment assessment (3rd Quarter 7-9/2011) outlined the following objective which read, " Given verbal prompts and physical assistance when necessary, [Client #3] will use a computer to assemble a simple 4,6,8,12 piece puzzle each day. "  Interview with the qualified intellectual disability professional (OOP) and the House Manager (HM) on 4/6/2012 at approximately 5:30 p.m. revealed they were not aware the day program staff was not allowing Client #3 to take part in any computer related activities. The QIDP indicated she planned to visit the day program to address the oversight.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure accurate documentation of a client 's targeted behaviors as outlined in the behavioral support plan for one of four sampled clients. [Client #3]  The finding includes:	W 252	Staff will be trained on the Behavior Support Plan and documentation for Individual #3 by his Psychologist. QIDP will schedule trainings on Client #3's Behavior Support Plan to ensure accurate documentation for target behaviors	5/31/12

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W 252	<p>Continued From page 10</p> <p>Observation on 4/4/2012 at approximately 4:57 p.m. revealed Client #3 ' s was observed yelling/screaming and running to the couch on three separate occasions. Each occasion of yelling/screaming and running occurred after he was instructed to arrange items on the dinner table.</p> <p>Review of Client #3 ' s Psychological Evaluation dated 11/29/2011 on 4/6/2011 at approximately 5:15 p.m. revealed agitation was one of three targeted behaviors identified to be addressed in his Behavioral Support Plan. The Psychological assessment goes on to describe agitation as, swishing belt in air, making noise with belt, waving belt around in the air, pacing around the home, up and down the stairs, back and forth, refusing to sit down, going around with no apparent purpose running and pushing people who are in his way while running, and yelling/screaming. " The assessment goes on to further recommend that each incidence of running and yelling/screaming should be documented on the ABC Data Collection sheets.</p> <p>Interview with the qualified Intellectual disability professional (QIDP) and the house manager (HM) on 4/5/2012 at 5:10 p.m. revealed the psychologist provided training on 1/27/2012 but did not specify what " type " of screaming the staff should target. The QIDP confirmed that screaming in general should be documented. Observation on 4/4/2012 and 4/5/2012 revealed approximately 8 instances of screaming (day program and home) but no documentation of the observed events were on record at the time of survey. In addition, both the MP and the HM confirmed that running was also a targeted</p>	W 252		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/06/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 311213TH STREET NW WASHINGTON, DC 20010
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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
W 252	Continued From page 11 behavior, but there was no evidence that the running observed on 4/4/2012 was documented by staff.	W 252		
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility failed to ensure that all targeted behaviors were documented as recommended by the psychologist.  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all adaptive equipment were being utilized in the manner prescribed to ensure a client's health and safety during times of ambulation for one of four sampled clients4Client #4]  The finding includes:  Observation on 4/4/2012 beginning at 4:10 p.m. revealed Client #4's gait belt was very loosely fastened and moved freely around his waist when Staff #6 grabbed it to help him walk around. It was also observed that staff held him by the shoulders, by his arm, and under his arms. Staff #9 was also observed later in the evening walking on either side of him and/or from behind while supporting him while he walked around.	W 436	Cross Reference W194 #1	5/7/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010
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W436	<p>Continued From page 12</p> <p>Additional record review on 4/6/2012 at approximately 2:15 p.m. revealed Client #4's Physical Therapy Annual Assessment dated 4/3/2012 recommended the following:</p> <p><b>Mobility Assessment:</b> "The resident was observed in his home environment. Per caregiver report, the resident is supervised at all times, secondary to his status as a fall risk. [Client #4] requires the use of a helmet and the assistance of a gait belt during all functional activities (transfers, standing, and ambulation) in order to ensure his safety, and to allow his caregiver to maintain control during those activities."</p> <p>Record review on 4/6/2012 at approximately 2:30 p.m. revealed Client #4's Mobility Training dated 4/6/2012 recommended the following:</p> <ol style="list-style-type: none"> <li>1. Fasten the gait belt around the resident's waist with the buckle placed in front of the resident.</li> <li>2. The belt should fit snugly, but you should be able to slip your fingers between the belt and the resident's waist.</li> </ol> <p>None of the staff working with Client #4 ensured that the gait belt was fastened to his waist properly. Interview with the facility's qualified intellectual disability professional (QIDP) and house manager (HM) confirmed training was completed on 4/6/2012, but the training was not specific to Client #4's needs. In addition, the HM and the QIDP confirmed that the gait belt should be snug and in proper fit while Client #4 walks around.</p>	W 436		

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

PRINTED: 04/24/2012  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  0410612012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	E PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 13 The facility failed to ensure staff was competent in properly fitting Client #4 ' s gait belt.	W 436		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010
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(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
1000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from 4/4/2012 through 4/6/2012. A random sampling of four residents was selected from a residential population of seven males with varying degrees of disabilities.</p> <p>The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the resident and administrative records, including the unusual incident reports.</p> <p>Qualified Mental Retardation Professional will be referred to as Qualified Intellectual Disabilities Professional within this report.</p>	1 000		
1183	<p><b>3508.4 ADMINISTRATIVE SUPPORT</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of four sampled residents. [Residents #2, #3 and #4]</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The QIDP failed to ensure outside services implemented active treatment programs as prescribed, for one of four sampled residents. (See 3521.3)</li> <li>2. Residents #1, #5, #6, and #7 went on vacation</li> </ol>	1183	<ol style="list-style-type: none"> <li>1. Cross Reference W120</li> <li>2. Cross Reference W140</li> </ol>	<p>5/7/12</p> <p>5/21/12</p>

Health Regulation & Licensing Administration  
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

*Constance A. Reese*

TITLE  
*Program Director*

(X8) DATE  
*5/3/12*

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  <b>0414612412</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 13TH STREET NW WASHINGTON, DC 20010</b>
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1183	<p>Continued From page 1</p> <p>beginning on which began on 8/7/2011 and ended on 8/10/2011. The facility allocated \$225.00 for meals for each resident to cover the four day outing. Review of the financial records on 4/5/2012 revealed the facility failed to ensure an accurate accounting of the \$225.00 for each resident as identified below:</p> <ul style="list-style-type: none"> <li>a. Resident #1 - Review of the receipts on hand revealed only \$60.99 was accounted for.</li> <li>b. Resident #5 - Review of the receipts on hand revealed only \$64.44 was accounted for.</li> <li>c. Resident #6 - Review of the receipts on hand revealed only \$89.91 was accounted for.</li> <li>d. Resident #7 - Review of the receipts on hand revealed only \$105.87 was accounted for.</li> </ul> <p>The QIDP and the house manager (HM) failed to ensure a full and accurate accounting of residents' personal funds, for four of seven residents residing in the facility. (See Federal Deficiency Report Citation W140)</p> <p>3. The QIDP failed to ensure accurate implementation of a resident's mealtime feeding protocol and use of a gait belt for two of four sampled residents. [See 3521.7(a) and 3521.7(k)]</p> <p>4. The QIDP failed to ensure that staff accurately documented data relative to residents' behavioral data, for one of the four sampled residents as identified below:</p> <p>Observation on 4/4/2012 at approximately 4:57 p.m. revealed Resident #3's was observed yelling/screaming and running to the couch on three separate occasions. Each occasion of yelling/screaming and running occurred after he was instructed to arrange items on the dinner table.</p>	1183	<p>3. Cross Reference W194</p> <p>4. Cross Reference W252</p>	<p>5/7/12</p> <p>5/31/12</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  0410612012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 311213TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	m PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1183	<p>Continued From page 2</p> <p>Review of Resident #3 's Psychological Evaluation dated 11/29/2011 revealed the following targeted behaviors:</p> <p>a. Agitation - defined as swishing belt in air, making noise with belt, waving belt around in the air, pacing around the home, up and down the stairs, back and forth, refusing to sit down, going around with no apparent purpose running and pushing people who are in his way while running, and yelling/screaming.</p> <p>b. Snatching Food</p> <p>C. Public Masturbation</p> <p>The assessment goes on to further recommend that each incidence of running and yelling/screaming should be documented on the ABC Data Collection sheets:</p> <p>Interview with the qualified intellectual disability professional (QIDP) and the house manager (HM) on 4/5/2012 at 5:10 p.m. revealed the psychologist provided training on 1/27/2012 but did not specify what " type " of screaming the staff should target. The QIDP confirmed that screaming in general should be documented. Observation on 4/4/2012 and 4/5/2012 revealed approximately 8 instances of screaming (day program and home) but no documentation of the observed events were on record at the time of survey. In addition, both the QIDP and the HM confirmed that running was also a targeted behavior, but there was no evidence that the running observed on 4/4/2012 was documented by staff.</p> <p>5. The QIDP failed to ensure that all adaptive equipment were being utilized in the manner prescribed to ensure a resident's health and</p>	1183	5. Cross Reference W194 #1	5/7/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HF003-0006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  0410612012
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1183	<p>Continued From page 3</p> <p>safety during times of ambulation for one of four sampled residents as identified below:</p> <p>Observation on 4/4/2012 beginning at 4:10 p.m. revealed Resident #4's gait belt was very loosely fastened and moved freely around his waist when staff grabbed it to help him walk around. It was also observed that staff held him by the shoulders, by his arm, and under his arms. Staff was also observed walking on either side of him and/or from behind while supporting him while he walks around.</p> <p>Additional record review on 4/6/2012 at approximately 2:15 p.m. revealed Resident #4's Physical Therapy Annual Assessment dated 4/3/2012 recommended the following:</p> <p>Mobility Assessment: "The resident was observed in his home environment. Per caregiver report, the resident is supervised at all times, secondary to his status as a fall risk. [Resident #4] requires the use of a helmet and the assistance of a gait belt during all functional activities (transfers, standing, and ambulation) in order to ensure his safety, and to allow his caregiver to maintain control during those activities."</p> <p>Record review on 4/6/2012 at approximately 2:30 p.m. revealed Resident #4's Mobility Training dated 4/6/2012 recommended the following:</p> <ul style="list-style-type: none"> <li>a. Fasten the gait belt around the resident's waist with the buckle placed in front of the resident</li> <li>b. The belt should fit snugly, but you should be able to slip your fingers between the belt and the resident's waist.</li> </ul> <p>None of the staff working with Resident #4</p>	1183		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/06/2012
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1183	Continued From page 4  ensured that the gait belt was fastened to his waist properly. Interview with the facility's qualified intellectual disability professional (QIDP) and house manager (HM) confirmed training was completed on 4/6/2012, but the training was not specific to Resident #4's needs. In addition, the HM and the QIDP confirmed that the gait belt should be snug and in proper fit while Resident #4 walks around.  The facility failed to ensure staff was competent in properly fitting Resident #4's gait belt.	1183		
1422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview and record review revealed, Resident #3's day program failed to implement programming objectives as written for one of four sampled residents. [Resident #3]  Observation on 4/5/2011 at 1:10 p.m. revealed Resident #3 was assigned to be in the computer room after lunch. Interview with the instructor in the computer room beginning at approximately 1:13 p.m. revealed Resident #3 takes part in putting together a 48 piece large block puzzle at least three times a week. The instructor indicated using the puzzle allows Resident #3 to focus on a task. The instructor also indicated that Resident #3 does not use the computers that are in the classroom for any activities. He stated that all Resident #3's activities are completed with items he can physically manipulate.	1422	Cross Reference W120	5/7/12

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1422	<p>Continued From page 5</p> <p>Record review on 4/6/2012 at approximately 1:00 p.m., revealed Resident #3's day treatment assessment (3rd Quarter 7-9/2011) revealed the following objective:</p> <p>Domain IV Cognitive Skills Objective 4a: Given verbal prompts and physical assistance when necessary, [Resident #3] will use a computer to assemble a simple 4,6,8,12 piece puzzle each day. Recommendation: This program will be continued.</p> <p>Interview with the qualified intellectual disability professional (QIDP) and the House Manager (HM) revealed they were not aware the day program staff was not allowing Resident #3 to take part in any computer related activities. The QIDP indicated she planned to visit the day program to address the oversight.</p> <p>The facility failed to ensure all outside services were implemented as written.</p>	1422		
1430	<p>3521.7(a) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils);</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's staff failed to ensure accurate implementation of a resident's mealtime feeding protocol and use of a gait belt for two of four sampled residents. [Resident #2</p>	1430	Cross Reference W194 #2	5/7/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/06/2012
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1430	<p>Continued From page 6 and #4]</p> <p>The finding includes:</p> <p>Observation on 4/4/2012 beginning at 4:55 p.m. revealed Resident #2 was observed eating dinner. Resident #2 was observed eating his meal and was offered his fluids at the end of the meal. Resident #2 was also observed slumped over his plate as he ate with staff assistance.</p> <p>Record review on 4/6/2012 at approximately 3:0 p.m. revealed Resident #2's Feeding Protocol dated 3/16/2012 recommended the following:</p> <ol style="list-style-type: none"> <li>1. Liquids: allow him to take sips of the beverage throughout the meal.</li> <li>2. Positioning: position MH in his chair at 90 degrees for all meals; ensure that his head is in an upright, neutral position.</li> </ol> <p>The staff working with Resident #2 was not observed implementing the above protocols. Interview with the facility's staff and house manager confirmed the surveyor's observation and indicated training would be scheduled to address the deficient practice.</p>	1430		
1441	<p>3521.7(k) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment);</p> <p>This Statute is not met as evidenced by:</p>	1441	Cross Reference W194 #1	5/7/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. NAME _____	(X3) DATE SURVEY COMPLETED  04/06/2012
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I441	<p>Continued From page 7</p> <p>Based on observation, staff interview and record review, the facility failed to ensure that all adaptive equipment were being utilized in the manner prescribed to ensure a resident's health and safety during times of ambulation for one of four sampled residents. [Resident #4]</p> <p>The finding includes:</p> <p>Observation on 4/4/2012 beginning at 4:10 p.m. revealed Resident #4's gait belt was very loosely fastened and moved freely around his waist when staff grabbed it to help him walk around. It was also observed that staff held him by the shoulders, by his arm, and under his arms. Staff was also observed walking on either side of him and/or from behind while supporting him while he walks around.</p> <p>Additional record review on 4/6/2012 at approximately 2:15 p.m. revealed Resident #4's Physical Therapy Annual Assessment dated 4/3/2012 recommended the following:</p> <p>Mobility Assessment: "The resident was observed in his home environment. Per caregiver report, the resident is supervised at all times, secondary to his status as a fall risk. [Resident #4] requires the use of a helmet and the assistance of a gait belt during all functional activities (transfers, standing, and ambulation) in order to ensure his safety, and to allow his caregiver to maintain control during those activities."</p> <p>Record review on 4/6/2012 at approximately 2:30 p.m. revealed Resident #4's Mobility Training dated 4/6/2012 recommended the following:</p> <p>1. Fasten the gait belt around the resident's waist</p>	I441		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETE  <b>04/06/2012</b>
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I441	<p>Continued From page 8</p> <p>with the buckle placed in front of the resident.</p> <p>2. The belt should fit snugly, but you should be able to slip your fingers between the belt and the resident's waist.</p> <p>None of the staff working with Resident #4 ensured that the gait belt was fastened to his waist properly. Interview with the facility's qualified intellectual disability professional (QIDP) and house manager (HM) confirmed training was completed on 4/6/2012, but the training was not specific to Resident #4's needs. In addition, the HM and the QIDP confirmed that the gait belt should be snug and in proper fit while Resident #4 walks around.</p> <p>The facility failed to ensure staff was competent in properly fitting Resident #4's gait belt.</p>	I441		